

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10143

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10141

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENEVOLE</u>			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BENEVOLE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BOONSBORO ROUTE 1</u>				d. STREET ADDRESS <u>BOONSBORO ROUTE 1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS ELMER ALDRIDGE</u>				4. DATE OF DEATH Month Day Year <u>JULY - 22 1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOV. 24, 1913</u>	9. AGE (In years last birthday) <u>53</u> yrs.	IF UNDER 1 YEAR Months Days <u>7 28</u>	IF UNDER 24 HRS. Hours Min. <u>7 28</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER BOONSBORO HIGH SCHOOL</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>PITTSBURGH PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>ALBERT ALDRIDGE</u>				14. MOTHER'S MAIDEN NAME <u>DORA FURLAW</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>173-03-0043</u>	17. INFORMANT <u>MRS. RUTH ALDRIDGE BOONSBORO MD. R.I.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancrease</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>July 1965</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July</u> , 1967, to <u>July</u> , 1967, that (I) (we) last saw the deceased alive on <u>7-15</u> 1967, and that death occurred at <u>7 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Charles C. Spencer</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-22-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Charles C. Spencer</u>				22d. ADDRESS <u>145 S. Prospect St. Hagerstown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>JULY 24, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>CEDAR LAWN PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>NEAR HAGERSTOWN MD.</u>		
24. FUNERAL DIRECTOR <u>John N. Best Sr. BOONSBORO MD</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 26 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

11111
11111
11111

CERTIFICATE OF DEATH

WILLIAMSON, JAMES B. JR.

Age 65 years

Decedent's Name

Place of Birth

Date of Birth

Place of Death

Time of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Witness

Signature of Minister

Signature of Undertaker

Signature of Burial

Signature of Interment

Signature of Burial

Signature of Interment

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10144

CERTIFICATE OF DEATH

10142

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 3 Days		d. STREET ADDRESS 107 Hunter Hill Drive	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle MICHAEL Last BECKLEY		4. DATE OF DEATH Month July Day 2 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 17 1900
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Watchman		10b. KIND OF BUSINESS OR INDUSTRY Bester- Long	
11. BIRTHPLACE (County & State, or foreign country) Md Clear Spring Wash Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME J. Ashby Beckley		14. MOTHER'S MAIDEN NAME Mary V. Speaker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-09-1159	
17. INFORMANT Frederick H. Beckley		Address Hagerstown Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) multiple pulmonary emboli 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) congestive heart failure DUE TO (c) arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH days weeks years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) huge toxic gutter		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 10, 1967 , to death , 19 67 , that (I) (we) last saw the deceased alive on 1 July 1967 , and that death occurred at 107 Hunter Hill Drive , from causes and on the date stated above.			
22a. SIGNATURE John C. Stauffer		22b. DATE SIGNED June 10, 1967	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/5/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REG. BY REGISTRAR JUL 6 1967	
25b. REGISTRAR'S SIGNATURE James Judge		DATE	

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10114

Washington

Washington County Hospital

101 Hunter Hill Drive

John Michael Gregory July 1955

June 14 1955

Barter-Long Great Spring Wash DC USA

J. A. Barry Buckley V. Spencer

211-02-1100-1000 J. A. Barry Buckley V. Spencer

101 Hunter Hill Drive

Handwritten notes and signatures

Bureau of Census

Andrew L. Collins Bureau of Census

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown		c. LENGTH OF STAY IN 1b 21 years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 3		d. STREET ADDRESS RFD 3	
3. NAME OF DECEASED (Type or print) First Roscoe Middle Edwin Last Beckley		4. DATE OF DEATH Month July Day 1 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-16-97
9. AGE (In years lost birthday) yrs. 69		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David L. Beckley		14. MOTHER'S MAIDEN NAME May J. Shifler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-36-2641	
17. INFORMANT Margaret Beckley, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardio Vascular Disease DUE TO (c) Several years		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1, 1967 , to July 1, 1967 , that (I) (we) last saw the deceased alive on June 14, 1967 , and that death occurred at 1:45 P. from causes and on the date stated above.			
22a. SIGNATURE A. E. W. Ditto, Jr.		22b. DATE SIGNED 7-3-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-4-67	
23c. NAME OF CEMETERY OR CREMATORY Salem Reformed Cem.		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REGD BY REGISTRAR JUL 6 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10113

UNITED STATES DEPARTMENT OF JUSTICE

WASHINGTON, D. C. 20535

TO: SAC, NEW YORK (100-100000)

FROM: SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

ATTENTION: [Illegible]

COPIES: [Illegible]

NOTES: [Illegible]

ADMINISTRATIVE: [Illegible]

ENCLOSURES: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10146

CERTIFICATE OF DEATH

10144

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown				d. STREET ADDRESS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Gateway Nursing Home				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Esther Middle R. Last Bidle				4. DATE OF DEATH Month 7 Day 2 Year 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/8/1876	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housekeeper		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.		12. CITIZEN OF WHAT COUNTRY U.S.	
13. FATHER'S NAME Daniel Bidle				14. MOTHER'S MAIDEN NAME Mary Cline			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Harold Holter, Middletown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis C.V. System Arteriosclerosis, a.s.						INTERVAL BETWEEN ONSET AND DEATH 4 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 15 June , 19 63 , to 2 July , 19 67 , that (I) (we) last saw the deceased alive on 29 June 19 67 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 3 July 1967	
22c. PHYSICIAN'S NAME (Type) Dr. William N. Fender				22d. ADDRESS Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7/5/67		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery		23d. LOCATION (City or Town) (County) (State) Middletown, Md.	
24. FUNERAL DIRECTOR ADDRESS Gladhill Company, Middletown				25a. REC'D BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE 	

10116

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH

NAME	DATE OF BIRTH	DATE OF DEATH
John Doe	1900-01-01	1980-01-01
SEX	AGE	PLACE OF BIRTH
Male	80	New York City
CAUSE OF DEATH	DATE OF INTERMENT	PLACE OF INTERMENT
Heart Disease	1980-01-01	New York City
Signature of Physician		
Signature of Registrar		

[Faint, illegible text at the bottom of the page, possibly a continuation of the certificate or a separate document.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 34 W. Franklin St.		d. STREET ADDRESS 34 W. Franklin St.	
3. NAME OF DECEASED (Type or print) First Ruth Middle Bishop Last Bishop		4. DATE OF DEATH Month July Day 31 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 7, 1905
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 6 Days 12 Hours 14 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Wash. Co. Welfare Board, Hag., Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2865 Bronchopneumonia Secondary DUE TO (b) to long standing + Profound DUE TO (c) Malnutrition		INTERVAL BETWEEN ONSET AND DEATH 5 days 6-12 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Edward W. Ditto, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 217 W. Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-10-67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE AUG 11 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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• 444 • DIXON, MULLER, AND STANLEY

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**FOR STATE
HEALTH DEPT.**

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VR A15ME (S)
6M 1/66

10148

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10145

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b - d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 237 East Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Calvin Last Bowers		4. DATE OF DEATH Month July Day 21 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-30-1924 9. AGE (In years last birthday) 43 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) electrician		10b. KIND OF BUSINESS OR INDUSTRY electrical contr.	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David R. Bowers		14. MOTHER'S MAIDEN NAME Sarah J. Barton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 216-14-6173	
17. INFORMANT Mrs. Ramona Bowers, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion H201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Several Years		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Hagerstown, Md.	
22. DATE SIGNED 7-22-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 7-24-67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR JUL 25 1967 DATE	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10143

CERTIFICATE OF DEATH

10146

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield		c. LENGTH OF STAY IN lb 31 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Highfield			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Upton Middle Lee Last Brown Sr.			4. DATE OF DEATH Month July Day 22 Year 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/18/1911		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Landis Tool Co.		11. BIRTHPLACE (County & State, or foreign country) Lantz, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ivan Brown				14. MOTHER'S MAIDEN NAME Alta Royer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-16-1936		17. INFORMANT Address Mrs. Esther N. Brown, Highfield Md., Box 11			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Coronary Vascular Disease DUE TO (c) 3 Months						INTERVAL BETWEEN ONSET AND DEATH 3 Months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 1967 to July 22 1967 that (I) (we) last saw the deceased alive on July 21 1967 , and that death occurred at 3:30 PM , from causes and on the date stated above.							
22a. SIGNATURE Robert A. Kiefer				22b. DATE SIGNED 24 July 67		22c. PHYSICIAN'S NAME (Type) Robert A. Kiefer	
22d. ADDRESS Blue Ridge Summit, Pa.				22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/25/67		23c. NAME OF CEMETERY OR CREMATORY St. Andrew		23d. LOCATION (City or Town) (County) (State) Waynesboro, Franklin Pa.	
24. FUNERAL DIRECTOR Walter Z. Groves				25a. REC'D BY REGISTRAR JUL 25 1967		25b. REGISTRAR'S SIGNATURE James Judge	

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Robert A. Kiefer

Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10150
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10147

1. PLACE OF DEATH a. COUNTY Wash.		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 2 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md.		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Smithsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital						d. STREET ADDRESS Rural #1				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First Henry		Middle Brunner		Last Brunner		4. DATE OF DEATH Month July		Day 24	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 25 1879		9. AGE (In years last birthday) 88		10. IF UNDER 1 YEAR Months 24	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pleasant Valley Wash.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Thomas S Brunner						14. MOTHER'S MAIDEN NAME Nancy Swope					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-42-3964		17. INFORMANT Mrs. Pearline Lewis Smithsburg RFD#1							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 446X DUE TO Anterior/Arterio Nephrosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Due to antecio/Arterio (c) Due to antecio/Arterio										INTERVAL BETWEEN ONSET AND DEATH 3 days 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 11/15 , 19 64 , to July 24 , 19 67 , that (I) (we) last saw the deceased alive on 7/23 , 19 67 , and that death occurred at 10:00 M. from causes and on the date stated above.											
22a. SIGNATURE E. H. Ford				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-25-67	
22c. PHYSICIAN'S NAME (Type) E. H. Ford				22d. ADDRESS 308 W. National Ave. Hagerstown Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 26 1967		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley				23d. LOCATION (City or Town) (County) (State) Smithsburg Wash Md			
24. FUNERAL DIRECTOR Minnich Funeral Home Smithsburg Md.						25a. REC'D BY REGISTRAR JUL 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10151

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10148

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>27 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Keller</u> Middle <u>Earl</u> Last <u>Buhrman</u>		4. DATE OF DEATH Month <u>July</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 2, 1901</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Car Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (State or foreign country) <u>Foxville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry G. Buhrman</u>		14. MOTHER'S MAIDEN NAME <u>Mary Reynolds</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-14-6683</u>	
17. INFORMANT <u>Mrs. Edith Buhrman</u>		Address <u>223 S. Locust St.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration of vomitus</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>multiple facial fractures</u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto accident</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>3:30</u> p.m. <u>7/29</u> 19 <u>67</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) <u>Hagerstown</u> (County) <u>Wash.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Howard N. Weeks</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> 8/4/67 ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) <u>Hagerstown, Maryland</u>	
EXAMINER'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		22. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8/1/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>	23d. LOCATION (City or Town) <u>Smithsburg - Washington - Md.</u> (County) <u> </u> (State) <u> </u>
24. FUNERAL DIRECTOR <u>Rest Haven Funeral Chapel</u> <u>Hagerstown, Md.</u>		25. REGD BY REGISTRAR <u>AUG 7 1967</u> DATE	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

Two for one -

Originally on Reg death form & should
have been H.E. - Film #391 - 8/7/67

W.D. 50

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10152

10149

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN		c. LENGTH OF STAY IN It 3 MONTHS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) CLEARVIEW NURSING HOME		d. STREET ADDRESS 38 NORTH AVENUE	
3. NAME OF DECEASED (Type or print) First PELLA Middle STRATOS Last CALLAS		4. DATE OF DEATH Month JULY Day 31 , Year 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 24, 1900
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) BEZANI, GREECE		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GREGORY STRATOS		14. MOTHER'S MAIDEN NAME PANSJIOTA GRIVACOS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MR. MICHAEL G. CALLAS, HAGERSTOWN, MARYLAND.		18. 1610 dr FOUNTAINBEAD RD.	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Vasc. Disease. DUE TO (c) Arteriosclerosis - Generalized.			INTERVAL BETWEEN ONSET AND DEATH 3 days 17 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) physician attended the deceased from JULY 22 , 1952 to JULY 31 , 1967, that (I) was saw the deceased alive on JULY 31 , 1967, and that death occurred at 12:45 M, from causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman		22b. DATE SIGNED AUGUST 1, 1967	
22c. PHYSICIAN'S NAME (Type) LLOYD A. HOFFMAN, M.D.		22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 8/3/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25. REC'D BY REGISTRAR AUG 7 1967	
		25b. REGISTRAR'S SIGNATURE <i>Charles Juzga</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reinsert carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, on in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10153

CERTIFICATE OF DEATH

10150

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 26 Yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Moller Apts				d. STREET ADDRESS Moller Apts			
3. NAME OF DECEASED (Type or print) First ANNA Middle ETHEL Last CHATKIN				4. DATE OF DEATH July 1 1967 19 67			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 1 1893		9. AGE (In years last birthday) 73 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk				10b. KIND OF BUSINESS OR INDUSTRY Chatkins Phar.		11. BIRTHPLACE (County & State, or foreign country) Pittsburg Penna	
13. FATHER'S NAME Charles Chatkin				14. MOTHER'S MAIDEN NAME Stella Pear			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Robert H. Chatkin Moller Apts	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, Generalized DUE TO (c) None						INTERVAL BETWEEN ONSET AND DEATH 1 hr, 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ---			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from May 1967 , to July 1967 , that (I) (we) last saw the deceased alive on June 19 67 and that death occurred at 0900 M, from causes and on the date stated above.							
22a. SIGNATURE J. Wilson				22b. DATE SIGNED 7/27/67		22c. PHYSICIAN'S NAME (Type) J. Wilson	
22d. ADDRESS				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/3/67		23c. NAME OF CEMETERY OR CREMATORY B'Nai Abraham Cem.		23d. LOCATION (City or Town) (County) (State) Half Way Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR JUL 6 1967		25b. REGISTRAR'S SIGNATURE J. Charles Jones	

10188

CHARTER OF TRUTH

JOHN WATSON

HAROLD WATSON

WILLIAM WATSON

ANNA

FRANK WATSON

CLARA

CHARLES WATSON

ROBERT L. WATSON

WATSON

WATSON

WATSON

WATSON

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WATSON

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10154

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10151

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN				c. LENGTH OF STAY IN 1b 5 YEARS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3 WOODBINE LANE				d. STREET ADDRESS 3 WOODBINE LANE			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle EDGAR Last COMBS				4. DATE OF DEATH Month JULY Day 27 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 12, 1907		9. AGE (In years last birthday) yrs. 60	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER		10b. KIND OF BUSINESS OR INDUSTRY MONUMENT WORKS		11. BIRTHPLACE (State or foreign country) MANCHESTER, KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. COMBS				14. MOTHER'S MAIDEN NAME MARGARET LITTLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. II		16. SOCIAL SECURITY NO. 216-07-1727		17. INFORMANT MRS. GLADYS B. COMBS, 3 WOODBINE LANE, HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive failure 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) athrosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH week						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard N. Weeks EXAMINER'S NAME (Type) HOWARD N. WEEKS, M.D.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		7/29/67 22. DATE SIGNED 580 NORTHERN AVE. HAGERSTOWN, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		23b. DATE THEREOF 8/1/67		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION (City or town) (County) (State) WASHINGTON, D.C.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR DATE JUL 31 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10155

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10152

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- Weverton			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL- Weverton		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) Robert Trenton Comer			4. DATE OF DEATH Month 7 Day 14 Year 1967		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/30		9. AGE (In years last birthday) yrs. 37
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carman B&O Railroad		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Emory F. Comer			14. MOTHER'S MAIDEN NAME Rachel H. Goode		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-249327	17. INFORMANT Address Mrs. Mary Catherine Comer, RFD 2 Knoxville		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) SEVERAL DAYS RECENT					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Dr. E.W. Ditto, Jr.		M.D.		22. DATE SIGNED 7-14-67	
EXAMINER'S NAME (Type) DR. E.W.DITTO, JR.		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, or other disposition Funeral Home	23b. DATE THEREOF 7/17/67	23c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Charlestown W. Va.	
24. FUNERAL DIRECTOR Feete Funeral Home		ADDRESS Brunswick Md.		25a. REC'D BY REGISTRAR JUL 18 1967	25b. REGISTRAR'S SIGNATURE J. P. Jones

10155

CORONARY OCCLUSION

ARTERIOSCLEROTIC HEART DISEASE

SEVERAL
RECENT

DR. F.W. DITTO, JR.

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10156 CERTIFICATE OF DEATH 10153											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) rural Hagerstown c. LENGTH OF STAY IN 1b 28 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD 2						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown d. STREET ADDRESS RFD 2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Walter Middle Hoge Last Conrad						4. DATE OF DEATH Month July Day 5 Year 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-7-94		9. AGE (In years last birthday) 72 yrs. IF UNDER 1 YEAR: Months 72 Days 0 Hours 0 Min. 0		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 10b. KIND OF BUSINESS OR INDUSTRY farm	
11. BIRTHPLACE (County & State, or foreign country) Jiles Co., Va.						12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Edmund Conrad						14. MOTHER'S MAIDEN NAME Nancy Croy					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 220-18-0108		17. INFORMANT Mrs. Emma Conrad, Hagerstown, Md. Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arteriosclerotic Cardio Vascular Disease (c) Several years										INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from May 1, 1967 , to July 5, 1967 , that (I) (we) last saw the deceased alive on June 30, 1967 , and that death occurred at 11:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-7-67			
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.						22d. ADDRESS Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 7-8-67		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park		23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.						25a. REC'D BY REGISTRAR JUL 10 1967		25b. REGISTRAR'S SIGNATURE [Signature]			

10186

Washington

Total population of years

1910

White 100,000

Colored 10,000

Foreign born 5,000

Native born 95,000

1910-1915 100,000

1915-1920 100,000

1920-1925 100,000

1925-1930 100,000

1930-1935 100,000

1935-1940 100,000

1940-1945 100,000

1945-1950 100,000

1950-1955 100,000

1955-1960 100,000

1960-1965 100,000

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10157

CERTIFICATE OF DEATH

10154

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 25 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. STREET ADDRESS 636 Guilford Ave.	
3. NAME OF DECEASED (Type or print) First John Middle McClelland Last Cunningham		4. DATE OF DEATH Month July Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 22, 1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 12 Days 12 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor		10b. KIND OF BUSINESS OR INDUSTRY Penna R.R.	
11. BIRTHPLACE (County & State, or foreign country) Pa Greencastle Franklin Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Cunningham		14. MOTHER'S MAIDEN NAME Elizabeth Lane	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 701-09-9361	
17. INFORMANT Mrs Hazel Cunningham		Address 636 Guilford Ave Hagerstown Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic heart disease DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 12 Hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Gastro-intestinal hemorrhage, repeated; Azotemia, multiple pulmonary embolism			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) William T. Layman attended the deceased from June 19 , 19 67 , to July 6 , 19 67 , that (I) we lost saw the deceased alive on July 6 , 19 67 , and that death occurred at 11:04 A.M., from causes and on the date stated above.			
22a. SIGNATURE William T. Layman, M.D.		22b. DATE SIGNED July 8, 1967	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg, Hag., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/10/67	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md.
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25. REC'D BY REGISTRAR DATE JUL 10 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

10182

STATE OF OHIO

W. H. HARRISON

1875

Washington County Hospital

John

Washington County Hospital

Dec. 22, 1902

Donor

James A. R. Green

Ellyson A. Green

General Cunningham

W. H. HARRISON

101-03-7501 Mrs. H. H. Cunningham

General Cunningham

unknown

Atrophic heart disease

Atrophic heart disease, regenerative, multiple, pulmonary

XXXXXX

July 6

June 10

11:04

July 6

July 6, 1902

100 Professional Arts Bldg., N.Y.

William J. Hays, N.Y.

Andrew E. Collins Funeral Home Inc.

101-03-7501 Mrs. H. H. Cunningham

100 Professional Arts Bldg., N.Y.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-10. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10158

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10155

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN (RURAL)			c. LENGTH OF STAY IN 1b 6 YEARS		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HALFWAY			d. STREET ADDRESS 2011 VIRGINIA AVENUE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. WASHINGTON COUNTY HOSPITAL			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First MARTIN Middle LEROY Last CUPERNALL			4. DATE OF DEATH Month JULY Day 24 Year 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 7, 1947	9. AGE (In years last birthday) yrs. 19	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TREE SURGEON		10b. KIND OF BUSINESS OR INDUSTRY****		11. BIRTHPLACE (State or foreign country) AUGENSBURG, NEW YORK	
13. FATHER'S NAME LEROY HIRAM CUPERNALL			14. MOTHER'S MAIDEN NAME KATHERINE LOVELAND		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-42-5831		17. INFORMANT MR. LEROY H. CUPERNALL, 2011 VIRGINIA AVE. HALFWAY, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull 823.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto collision-car hit utility pole			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12:30xx 7/24 1967		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street	
		20f. (City or town) (County) (State) Hagerstown, Wash., Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> 7/25/67 22. DATE SIGNED					
ACTUAL SIGNATURE Howard N. Weeks EXAMINER'S NAME (Type) HOWARD N. WEEKS, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 580 NORTHERN AVE. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/27/67	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.			25a. REC'D BY REGISTRAR DATE JUL 31 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

10128

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #0 & 9 Film #G391 8/3/67 ph

10159

CERTIFICATE OF DEATH

10156

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 42 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL SMITHSBURG		d. STREET ADDRESS 185 NAVAHO CIRCLE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY PEARL DANNER		4. DATE OF DEATH Month Day Year JULY 24, 19 67	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1891 JULY 1, 1886
9. AGE (In years last birthday) yrs. 81 1/2		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
11. BIRTHPLACE (County & State, or foreign country) PIEDMONT, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SANFORD MONTGOMERY		14. MOTHER'S MAIDEN NAME SUSAN (UNKNOWN)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. MARY E. MORGANTHALL, SMITHSBURG, MD.		Address ROUTE #2 BOX 185	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hepatorenal Failure DUE TO (b) Metastatic CA. Endometrium DUE TO (c) 172X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH 3 wks. 18 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 4/3 1967 7/24 67	
21. I certify that (I) (this hospital) attended the deceased from 4/3 , 19 67 to 7/24 , 19 67 , that (I) (we) last saw the deceased alive on 7/24 , 19 67 and that death occurred at 5 PM , from causes and on the date stated above.			
22a. SIGNATURE D. J. Boyer		22b. DATE SIGNED JULY 25, 1967	
22c. PHYSICIAN'S NAME (Type) DAVID J. BOYER, M.D.		22d. ADDRESS 136 N. POTOMAC ST. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/27/67	
23c. NAME OF CEMETERY OR CREMATORY MARVIN HILL CHAPEL		23d. LOCATION (City or Town) (County) (State) MT. AIRY, HOWARD CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR JUL 31 1967	
25b. REGISTRAR'S SIGNATURE Charles M. Rouzer		DATE	

100750

Report of the
Director of the
Bureau of the
Census

4/3 - 1/24/07

1/24/07

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 10160 CERTIFICATE OF DEATH 10157											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital					d. STREET ADDRESS E. Northern Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary Elva Leslie Davis			First Middle Last		4. DATE OF DEATH July 12, 1967		Month Day Year				
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-10-1891		9. AGE (in years last birthday) 76 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Blairs Valley, Pa.			12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME John S. Wilson					14. MOTHER'S MAIDEN NAME Joann Robinson						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. 215-14-1785T		17. INFORMANT George Davis, Hagerstown, Md.			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, Gen. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Umbilical Hernia										INTERVAL BETWEEN ONSET AND DEATH 6 hrs. not known	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 7/7 , 19 67 , to 7/12 , 19 67 , that (I) (we) last saw the deceased alive on 7/12 , 19 67 , and that death occurred at 6:15 M, from the causes and on the date stated above.											
22a. SIGNATURE Harold Riebo			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/12/67				
22c. PHYSICIAN'S NAME (Type) HAROLD RIEBO			22d. ADDRESS 159 W. Washington St.								
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 7-14-67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery			23d. LOCATION (City, town or county) (State) Hagerstown, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.					ADDRESS		25a. REC'D BY REGISTRAR JUL 17 1967				
							25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>				

10100

Washington

5 years

Washington

Washington, D.C.

Mary Alice Lewis

1911-1912

Washington, D.C.

John E. Wilson

John E. Wilson

1911-1912 George Lewis, Washington, D.C.

Best Representative
George Lewis, D.C.

Washington, D.C.

John E. Wilson
George Lewis

John E. Wilson

George Lewis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10161

CERTIFICATE OF DEATH

10158

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN TB 50 YEARS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 2613 VIRGINIA AVENUE			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle EDWARD Last DAWSON				4. DATE OF DEATH Month JULY Day 17 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 26, 1893	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED P.E. EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY POTOMAC EDISON CO.		11. BIRTHPLACE (County & State, or foreign country) PAGE CO. VIRGINIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH DAWSON				14. MOTHER'S MAIDEN NAME SARSH WEAVER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO *****		16. SOCIAL SECURITY NO. 214-10-5537-A		17. INFORMANT HAGERSTOWN, MARYLAND. TRUST DEPT. FIRST NATIONAL BANK OF MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hemorrhagic diathesis 1539 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) fibrosarcoma DUE TO (c) carcinoma of bowel						INTERVAL BETWEEN ONSET AND DEATH weeks 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the doctor) attended the deceased from _____, 19____, to death , 19____, that (I) (we) last saw the deceased alive on 16 July , 19 67 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE John C. Stauffer				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) JOHN C. STAUFFER, M.D.	
22d. ADDRESS 145 S. PROSPECT ST. HAGERSTOWN, MD.		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/19/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR JUL 20 1967		25b. REGISTRAR'S SIGNATURE Charles Rouzer	

10101

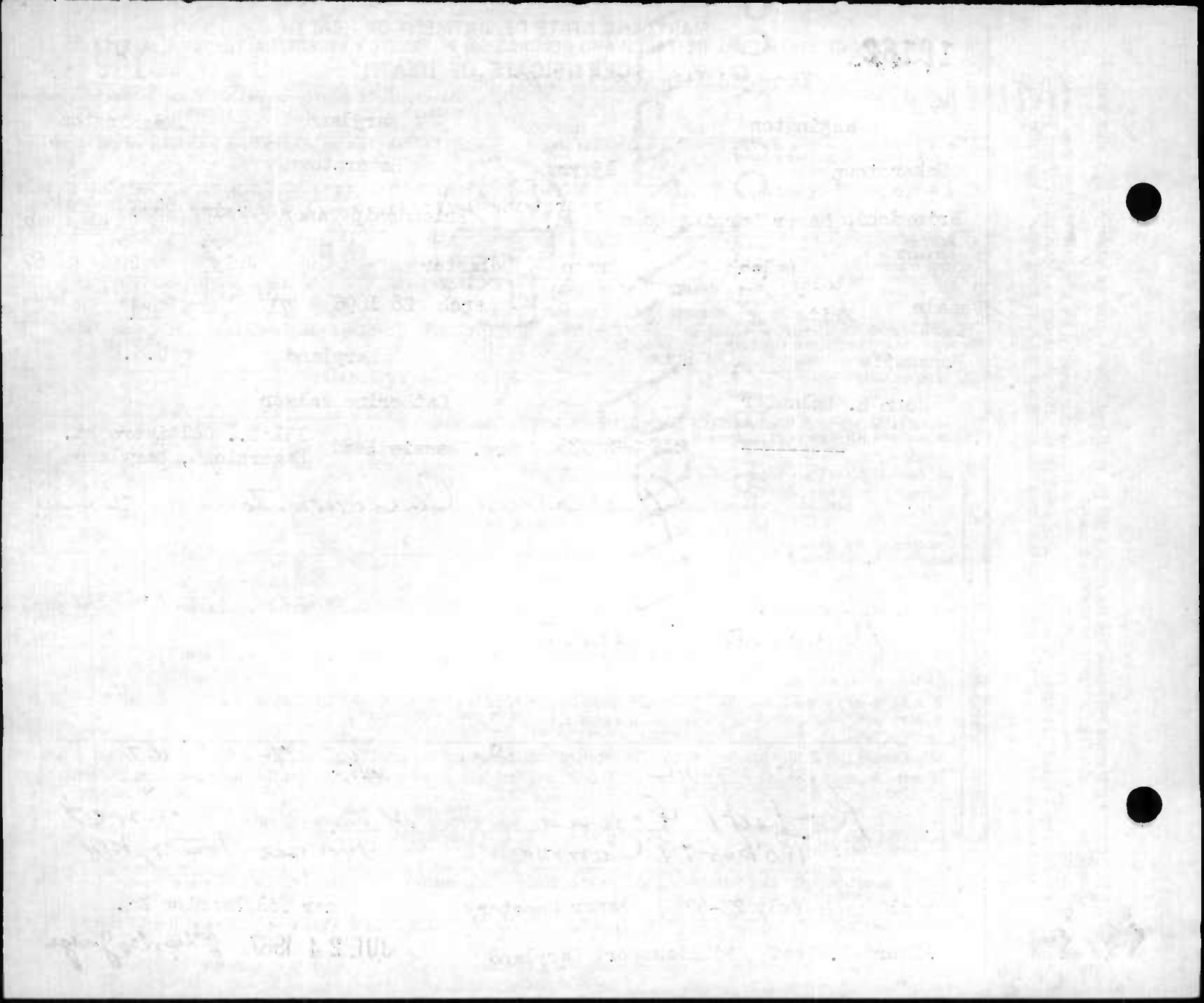
10101

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10159 Item #2d Film #0391 6/2/67 ph 10159 CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 15 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 21-1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Friendship Manor Nursing Home Md.						d. STREET ADDRESS Williamsport Rt. 1 Friendship Manor Nursing Home			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last Beulah Grace Delauter						4. DATE OF DEATH Month Day Year July 20 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 28 1896		9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 3 21	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John E. Delauter						14. MOTHER'S MAIDEN NAME Catherine Palmer					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 219 542 335		17. INFORMANT Mrs. Bessie Head		Address 131 E. Baltimore St. Hagerstown, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Carcinomatosis 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 2 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Dec, 1965, to 7-20, 1967, that (I) (we) last saw the deceased alive on 7-20-1967, and that death occurred at 4:50 PM, from the causes and on the date stated above.											
22a. SIGNATURE Robert P. Conrad M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-21-67			
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad						22d. ADDRESS Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 23-67		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City, town or county) (State) Near Tilghmanton Md.					
24. FUNERAL DIRECTOR Albert L. Leaf						ADDRESS Williamsport Maryland		25a. REC'D BY REGISTRAR DATE JUL 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	



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10163		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201		10160	
CERTIFICATE OF DEATH					
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG POOL		c. LENGTH OF STAY IN 1b 18 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG POOL	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) HOME, BIG POOL			d. STREET ADDRESS BIG POOL		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last CHESTER WILLIAM DESHONG			4. DATE OF DEATH Month Day Year JULY 12, 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/29/1905	9. AGE (In years lost birthday) yrs. 61	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY LUMBER		11. BIRTHPLACE (County & State, or foreign country) FULTON CO, M PENNA.	
13. FATHER'S NAME SAMUEL LOGUE DESHONG			14. MOTHER'S MAIDEN NAME ELSIE IRENE DECKER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 204-018702		17. INFORMANT Address ROBERT C. DESHONG, BIG POOL, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Heart Disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) Hypertension					INTERVAL BETWEEN ONSET AND DEATH instant
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June , 1966, to July 12 , 1967, that (I) (we) last saw the deceased alive on May 2 , 1967, and that death occurred at 6P M, from causes and on the date stated above.					
22a. SIGNATURE L.M. SHAFER		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/14/67	
22c. PHYSICIAN'S NAME (Type) L.M. SHAFER		22d. ADDRESS Hancock, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/15/67	23c. NAME OF CEMETERY OR CREMATORY SIDLING HILL CHRISTIAN HARRISONVILLE, PENNA.		23d. LOCATION (City or Town) (County) (State) Hancock, Md.	
24. FUNERAL DIRECTOR Richard J. Grove		ADDRESS Hancock, Md.		25. REGISTRY REGISTRAR JUL 17 1967	
VR A15 (4) 25M 1/67		25b. REGISTRAR'S SIGNATURE Charles Judge			

62302

NOT FOR READING

QUALITY

NOTES IN THE AREA

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WESTERN MAILING SERVICE

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15 SEP 1995

FULTON CO. X PENNA.

SAVIER LOGUE DESIGN

RECEIVED - 34341 118.13

[illegible]

ANNEX 2. ESTIMATION OF THE EFFECT OF THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Months	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 79 Washington County Hospital		d. STREET ADDRESS 117 Potomac St.	
3. NAME OF DECEASED (Type or print) First William Middle Henry Last Easterday		4. DATE OF DEATH Month July Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 5, 1885
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months 1 Days 28 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Water Co.	
11. BIRTHPLACE (County & State, or foreign country) Boonsboro, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frisby Easterday		14. MOTHER'S MAIDEN NAME Martha Ann Easterday	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-05-6899	
17. INFORMANT Mr. Edmund R. Easterday, 623 N. Locust St.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Atherosclerotic Cardiac Vascular Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May 5, 1967 , to July 3, 1967 , that (I) (we) last saw the deceased alive on June 28, 1967 , and that death occurred at 7:00 AM , from causes and on the date stated above.			
22a. SIGNATURE Dale W. LeVan / M.D.		22b. DATE SIGNED July 4, 1967	
22c. PHYSICIAN'S NAME (Type) Dale W. LeVan / M.D.		22d. ADDRESS Boonsboro, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-6-67	
23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REG. BY REGISTRAR 1967 25b. REGISTRAR'S SIGNATURE [Signature]	

REPORT OF THE SECRETARY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10165

CERTIFICATE OF DEATH

10162

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Yrs	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 228 No Potomac St	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 228 No Potomac St		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MARY LELLY ENGROFF		4. DATE OF DEATH Month Day Year July 4 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 18 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Juniata Co Penna		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Leech		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-52-2110	
17. INFORMANT Mary C. Braham		Address 228 No potomac St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertension Heart Disease DUE TO (c) 3 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 5/25		20f. (City or town) (County) (State) 6/5 7/4 67	
21. I certify that (I) (this hospital) attended the deceased from 5/25 , 19 65 , to 7/4 , 19 67 , that (I) (we) last saw the deceased alive on 6/13 , 19 67 , and that death occurred at 4:45 PM , from causes and on the date stated above.			
22a. SIGNATURE Donald E Martin		22b. DATE SIGNED 7/5/67	
22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.		22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/7/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR JUL 10 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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Второй шаг

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 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10166
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10163

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rfd. 2 Mapleville				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Nancy Evelyn Faulder				4. DATE OF DEATH Month Day Year July 13, 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1889	9. AGE (In years lost birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min. 4 3		IF UNDER 24 HRS. Hours Min. 4 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME David E. Stine				14. MOTHER'S MAIDEN NAME Clara Baker			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs. Daisy Faulder, Boonsboro Rfd. 2, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June , 19 65 , to July 13 , 19 67 , that (I) (we) last saw the deceased alive on July 12 , 19 67 , and that death occurred at 6:30 M. from causes and on the date stated above.							
22a. SIGNATURE Dr. E. W. Ditto, Jr.				22b. DATE SIGNED 7-15-67		22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.	
22d. ADDRESS Hagerstown, Md.		22e. MED. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-16-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Lena Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Lena, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR JUL 18 1967		25b. REGISTRAR'S SIGNATURE 	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10167

CERTIFICATE OF DEATH

10164

1. PLACE OF DEATH a. COUNTY <u>Washington Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN, MD</u>		c. LENGTH OF STAY IN 1b <u>21 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Co Hospital</u>				d. STREET ADDRESS <u>109 Jackson Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Brenda</u> Middle <u>Sue</u> Last <u>FERNOW</u>				4. DATE OF DEATH Month <u>7</u> Day <u>31</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/21/59</u>		9. AGE (In years lost birthday) yrs. <u>7</u>	IF UNDER 1 YEAR Months <u>7</u> Days <u>31</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>—</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US.</u>	
13. FATHER'S NAME <u>Clyde Lee FERNOW</u>				14. MOTHER'S MAIDEN NAME <u>Doris Jean Truax</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Clyde FERNOW - Williamsport, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>2890 Congestive Heart Failure</u> DUE TO (b) <u>Uremia</u> DUE TO (c) <u>TANCONI Syndrome</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>6 mos.</u> <u>7 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>NONE</u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/21</u> , 19 <u>59</u> , to <u>7/31</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/31</u> , 19 <u>67</u> , and that death occurred at <u>1:30 P</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Richard A. Young</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7/31/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard A. Young</u>				22d. ADDRESS <u>101 KING STREET, HAGERSTOWN, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>		23b. DATE THEREOF <u>8-3-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Berkley Springs, W.Va.</u>	
24. FUNERAL DIRECTOR <u>Minnich Funeral Home, Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 4 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10168

10165

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN TB D.O.A.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Connocheague Park		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last FLETCHER				4. DATE OF DEATH Month July Day 29 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jany 4 1908		9. AGE (In years last birthday) 59 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Roofing Co.		11. BIRTHPLACE (State or foreign country) Bedford County Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Fletcher				14. MOTHER'S MAIDEN NAME Clara Jones			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. -----		17. INFORMANT Address Mrs Edna M. Long Hagerstown Md. R#4			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Basal skull fracture 9000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH sudden							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Victim fell down steps at his home					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 1:00 p.m. 7/29 19 67		20d. INJURY OCCURRED 2 While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown, Wash., Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Howard N. Weeks M.D. EXAMINER'S NAME (Type) Howard N. Weeks, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 580 Northern Ave. Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/1/67		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR DATE AUG 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

10108

Washington, D.C. 20540

Department of the Interior

Geological Survey

Washington, D.C. 20540

July 19, 1967

Dear Sir:

Enclosed for you are

two copies of the report

Very truly yours,

Director

Geological Survey

Washington, D.C. 20540

Enclosure

Very truly yours,

Director

FOR STATE
HEALTH DEPT.

10169

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10166

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE UTAH b. COUNTY TOOELE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALT LAKE CITY		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1990 S. 21 ST. EAST		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RICHARD VERGIL FOWLER				4. DATE OF DEATH 7-1 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 29, 1944		9. AGE (In years last birthday) 22 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ENGINEERING TECHN.		10b. KIND OF BUSINESS OR INDUSTRY U.S. GOVERNMENT		11. BIRTHPLACE (State or foreign country) TAKOMA, WASHINGTON		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RICHARD H. FOWLER				14. MOTHER'S MAIDEN NAME FLORINNE ANKUDOWICZ			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN		16. SOCIAL SECURITY NO. 539-40-9008		17. INFORMANT MRS. SHARON T. FOWLER, 1990 S. 21 ST. EAST, SALT LAKE CITY, UTAH.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) FRACTURED SKULL WITH INTRACEREBRAL HEMORRHAGE AND SUB DURAL HEMATOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. SEVERELY BEATEN BY UNKNOWN PERSONS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) PUBLIC HIGHWAY 20c. TIME OF INJURY Month, Day, Year 6-30 19 67 Hour a.m. p.m. 2:30 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, city, town, or other) CHAMBERSBURG, PA. 20f. (City or town) (County) (State) 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> 22. DATE SIGNED 7-2-67 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 7/5/67 23c. NAME OF CEMETERY OR CREMATORY TOOELE CITY CEMETERY 23d. LOCATION (City or Town) (County) (State) TOOELE CITY, TOOELE, UTAH. 24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND. 25. REC'D BY REGISTRAR JUL 5 1967 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>							

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

10168

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ADULT MALE

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ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

FRACTURED SKULL WITH INTRACEREBRAL
HEMORRHAGE AND SUB DURAL HEMATOMA

40 HRS.

SEVERELY BEATEN BY UNKNOWN PERSONS

X PUBLIC HIGHWAY CHAMBERSBURG,

67

6-30

2:30

X

X

X

7-2-67

DR. E.W. DITTO, JR.

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

ST. LOUIS HOSPITAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10170

10167

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 42 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 43 SOUTH PROSPECT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORMAN Middle EDGAR Last GEISELMAN				4. DATE OF DEATH Month JULY Day 9, Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH JUNE 29, 1899		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALES MGR.		10b. KIND OF BUSINESS OR INDUSTRY MANUFACTURING FIRM		11. BIRTHPLACE (County & State, or foreign country) HANOVER, PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME DANIEL GEISELMAN				14. MOTHER'S MAIDEN NAME AMELIA STAMBAUGH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. 214-09-0023 A		17. INFORMANT ROUTE 1 MRS. LUCILLE RONEY, CLEAR SPRING, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Acute myocardial infarction DUE TO (b) Coronary arteriosclerosis - DUE TO (c) Anterior wall Cardio. Dis.						INTERVAL BETWEEN ONSET AND DEATH 2-3 days years years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic lymphocytic leukemia, Diabetes Mellitus							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 19 57 to date , 19 67 , that (I) (we) last saw the deceased alive on July 19 67 , and that death occurred at 5 PM , from causes and on the date stated above.							
22a. SIGNATURE Richard T. Binford				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED JULY 12, 1967	
22c. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D.				22d. ADDRESS 1135 POTOMAC AVE. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/12/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR DATE JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles Rouzer	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10171

CERTIFICATE OF DEATH

10168

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cascade, Md. Rural</u>		c. LENGTH OF STAY IN 1b <u>30 years</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cascade (Rural)</u>		211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>R.D.1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Guernon</u> Middle <u>C.</u> Last <u>Harbaugh</u>		4. DATE OF DEATH Month <u>July</u> Day <u>16</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Fredrick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Arben Harbaugh</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Miller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>173-03-2686</u>	
17. INFORMANT <u>Mrs. Richard E. Harbaugh</u>		Address <u>Cascade, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction, acute</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-15 min.</u> <u>1-2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2 March 1957</u> to <u>16 July 1967</u> , that (I) (we) last saw the deceased alive on <u>15 July 1967</u> , and that death occurred at <u>104 M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Harry H. Youngs Jr.</u>		22b. DATE SIGNED <u>7-18-67.</u>	
22c. PHYSICIAN'S NAME (Type) <u>Harry H. Youngs Jr.</u>		22d. ADDRESS <u>Blue Ridge Summit, Penna.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/19/1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Bethel</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington County Md.</u>	
24. FUNERAL DIRECTOR <u>Walter Z. Shore</u>		25a. REC'D BY REGISTRAR <u>Waynesboro, Pa.</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>JUL 21 1967</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10172

CERTIFICATE OF DEATH

10169

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please re-attach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Penna b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 Years	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Jackson Conv. Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last MINNIE MAE HARP		4. DATE OF DEATH Month Day Year July 29 1967 19	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jany 9 1874
9. AGE (In years last birthday) 93 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	11. BIRTHPLACE (County & State, or foreign country) Mt Lena Wash Co Md.
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Luther Lumm	
14. MOTHER'S MAIDEN NAME Mary McKinsey		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Address Reno O. Harp 906 Mulberry Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) RHEUMATIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 27, 1967 , to July 29, 1967 , that (I) (we) saw the deceased alive on July 28, 1967 , and that death occurred at 4:55 PM , from causes and on the date stated above.			
22a. SIGNATURE W. T. Layman, M.D.		22b. DATE SIGNED AUG 1, 1967	
22c. PHYSICIAN'S NAME (Type) W. T. LAYMAN, M.D.		22d. ADDRESS 5 PUBLIC SQUARE HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/1/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR AUG 2 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jones			

10173

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Wynneboro

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111 West Ninth St

Jackson County, Tenn

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10173

CERTIFICATE OF DEATH

10170

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
c. LENGTH OF STAY IN 1b 49 YEARS		d. STREET ADDRESS 1041 GEORGIA AVENUE,	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1041 GEORGIA AVENUE,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EDGAR Middle CHARLES Last HELMAN		4. DATE OF DEATH Month JULY Day 7 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 24, 1902
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MAINTENANCE & W.M.D. RAILROAD		10b. KIND OF BUSINESS OR INDUSTRY W.M.D. RAILROAD	
11. BIRTHPLACE (County & State, or foreign country) FRANKLIN CO. PENNSYLVANIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WAYS DEPT. IVAN HELMAN		14. MOTHER'S MAIDEN NAME CHARLOTTE HELMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 705-10-5786	
17. INFORMANT MRS. VIRGINIA H. HELMAN, HAGERSTOWN, MD.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease DUE TO (c) Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 7 , 19 67 , to July 7 , 19 67 , that (I) (we) saw the deceased alive on July 7 , 19 67 , and that death occurred at 3:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE William T. Layman, M.D.		22b. DATE SIGNED JULY 8, 1967	
22c. PHYSICIAN'S NAME (Type) WILLIAM T. LAYMAN, M.D.		22d. ADDRESS PROFESSIONAL ARTS BLDG. HAGERSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/10/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY,	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH.CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR JUL 14 1967	
25b. REGISTRAR'S SIGNATURE Charles Juzer			

10173



Acute coronary occlusion

Arteriosclerotic heart disease

[Handwritten signature]

JUL 1 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 10171
10174
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 43 years d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1260 Ravenswood Hgths e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Floyd House Hightman		4. DATE OF DEATH July 15, 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-25-1900 9. AGE (In years last birthday) 66 yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) letter carrier 11b. KIND OF BUSINESS OR INDUSTRY post office		11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md. 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Cecil Hightman		14. MOTHER'S MAIDEN NAME Mary House	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 220-42-5934 17. INFORMANT Mrs. Pauline Hightman, Hagerstown, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cerebro-Vascular Thrombosis - Uremia			INTERVAL BETWEEN ONSET AND DEATH 4 DAYS Yes
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1963 to 15 July , 1967, that (I) (we) last saw the deceased alive on 15 July , 1967, and that death occurred at 6:57 AM, from the causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED 17 July 67	
22c. PHYSICIAN'S NAME (Type) W.N. FENDER		22d. ADDRESS 218 N. Potomac St. Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-18-67	23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Mem. Park	23d. LOCATION (City, town or county) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR JUL 19 1967 DATE	25b. REGISTRAR'S SIGNATURE 

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN TB 9 Yrs d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home Inc		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederock c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frederick d. STREET ADDRESS 223 So Market St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BLANCHE ESTELLE HILDEBRAND First Middle Last 4. DATE OF DEATH July 10 1967 Month Day Year		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Feb 12 1879 9. AGE (In years lost birthday) 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book keeper 10b. KIND OF BUSINESS OR INDUSTRY ----		11. BIRTHPLACE (County & State, or foreign country) Frederick Frederick Co Md 12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis M. Hildebrand 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service) --		14. MOTHER'S MAIDEN NAME Laura V. Staley 16. SOCIAL SECURITY NO. 214-10-1811 17. INFORMANT Address Rev Mark G. Wagner 2750 Virginia Ave Williamsport Md 21795	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X Hypertensive C.V. Dis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 8-15 , 19 65 , to 7-10 , 19 67 , that (I) (we) last saw the deceased alive on 7-6-1967 , and that death occurred at 4 A M, from causes and on the date stated above.	
22a. SIGNATURE Robert P. Conrad M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) Robert P. Conrad 22d. ADDRESS Hagerstown Md		22b. DATE SIGNED 7-10-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF July 19-1967 23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery 23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701		25a. REC'D BY REGISTRAR JUL 19 1967 25b. REGISTRAR'S SIGNATURE Charles Judge	
24. FUNERAL DIRECTOR M.R. Etchison & Son ADDRESS Whitmore Frederick, Md. 21701			

070-10401-11

Page 10

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SYSTEMS DIVISION, JAN 20 1961

Frederick, W. S. 1701

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Frederick, Md. 21701

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10176

CERTIFICATE OF DEATH

10173

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport				c. LENGTH OF STAY IN TB 1 Yr-2mos			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home, Inc.				d. STREET ADDRESS 5709 Woodcrest			
3. NAME OF DECEASED (Type or print) First MARY Middle NMM Last HOFFMAN				4. DATE OF DEATH Month July Day 21 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 14, 1876		9. AGE (In years lost birthday) 91 yrs.	10. IF UNDER 1 YEAR Months 30 Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housekeeper		11. BIRTHPLACE (County & State, or foreign country) Penna. Pittsburg, Alleghany Cty		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME John Hoffman				14. MOTHER'S MAIDEN NAME Helena Hogge			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 312-32-2294A		17. INFORMANT 2750 Virginia Ave Rev. Mark Wagner, Williamsport, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive C. V. Dis DUE TO (c) 15 yrs.							INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 7-15 , 1967, to 7-21 , 1967, that (I) (we) last saw the deceased alive on 7-21 , 1967, and that death occurred at 10:20 P.M., from causes and on the date stated above.							
22a. SIGNATURE Robert P. Conrad M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-22-67	
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad				22d. ADDRESS Hagerstown, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 24, 1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR A. K. Coffman Funeral Home, Inc.				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR JUL 28 1967	
				25b. REGISTRAR'S SIGNATURE [Signature]			

10170

William

William

Honorable Cannon Home, Inc.

1917

Female White

Female

John Hoffman

no

Holmes

2700 Virginia Ave
Baltimore, Md

1917

Mar. 14, 1917

U.S.A.

Baltimore, Md

A. K. Cannon Home, Inc.
Baltimore, Md.
Burial July 25, 1917
Mr. Oliver Cemetery Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10177

CERTIFICATE OF DEATH

10174

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, give R.U.C. and nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 15 BRIGHTWOOD CIRCLE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle BLANCHE Last HORN				4. DATE OF DEATH Month JULY Day 25 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/10/1886		9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during part of working life, if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM A. HOSE				14. MOTHER'S MAIDEN NAME MARY E. BAUGHMAN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. PATRICIA MYERS HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive cardiovascular disease, arteriosclerotic DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						INTERVAL BETWEEN ONSET AND DEATH 30 min. Indefinite	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from July 25, 1967 to July 25, 1967 , that (4) (we) last saw the deceased alive on July 25, 1967 , and that death occurred at 10:35 A.M. from causes and on the date stated above.							
22a. SIGNATURE <i>B. B. Kneisley</i>				22b. DATE SIGNED 7/26/67		22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.	
22d. ADDRESS 148 West Washington St. Hagerstown, Maryland		22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/27/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.	
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUL 31 1967		25b. REGISTRAR'S SIGNATURE <i>James J. Jones</i>	

UNITED STATES OF AMERICA

1952

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IN THE DISTRICT COURT OF THE UNITED STATES FOR THE DISTRICT OF COLUMBIA

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FOR STATE
HEALTH/DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME
5M 1/63

<div> <div>10178</div> <div> <div>1</div> <div>FOR STATE HEALTH/DEPT.</div> </div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>10175</div> </div>													
1. PLACE OF DEATH a. COUNTY Washington <div>MARYLAND</div>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Mass. b. COUNTY Bristol c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Dighton d. STREET ADDRESS 707 Green Acres							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fort Ritchie c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) U.S. Army Dispensary						e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North Dighton d. STREET ADDRESS 707 Green Acres							
3. NAME OF DECEASED (Type or print) JANE CHAMBERLAIN First Middle Last						4. DATE OF DEATH Month Day Year 7 3 1967							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 18, 1900		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Companion				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Stoneham, Mass.				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Arthur Webber						14. MOTHER'S MAIDEN NAME Ada Chamberlain							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Donna Lee Horton, Bldg 469, Ft. Ritchie, Md. Address							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thromboses DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic coronary artery DUE TO (c) disease												INTERVAL BETWEEN ONSET AND DEATH Sudden 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Howard N. Weeks				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 7/4/67 580 North Main St. Haverhill, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7/8/1967		22c. NAME OF CEMETERY OR CREMATORY Colebrook Cemetery				22d. LOCATION (City, town, or county) Rehoboth, Mass.			
23. FUNERAL DIRECTOR A. Marlin Poe						ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR JUL 6 1967		24b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

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College of Arts and Sciences

Specials

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10179

10176

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN c. LENGTH OF STAY IN 1b LIFE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 525 RIDGE AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) JAMES GRANTIAN HOWELL First Middle Last		4. DATE OF DEATH Month JULY Day 28 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/6/1918
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEAVER		10b. KIND OF BUSINESS OR INDUSTRY TEXTILE MFG. CO.	11. BIRTHPLACE (State or foreign country) MARYLAND
13. FATHER'S NAME LEE HAMILTON HOWELL		14. MOTHER'S MAIDEN NAME NEVA GOENS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 220-09-7513	
17. INFORMANT MRS. HELEN B. HOWELL		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 9298 IMMEDIATE CAUSE (a) Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN DEATH AND DEATH sudden			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Dived into River To check Boat	
20c. TIME OF INJURY Month, Day, Year Hour 7:00 p.m. 7/28 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) State River
20f. (City or town) Hagerstown Wash. (County) Md. (State)		21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE Howard N. Weeks EXAMINER'S NAME (Type) Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 7/31/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. PARK	23d. LOCATION (City or Town) HAGERSTOWN WASH. MD. (County) (State)
24. FUNERAL DIRECTOR W. T. Normant Address Hagerstown Md.		25a. REC'D BY REGISTRAR AUG 1 1967 DATE	25b. REGISTRAR'S SIGNATURE Charles Judge

27101

WASHINGTON

MARYLAND

WASHINGTON

HAGERSTOWN

ALBANY

ST. LOUIS, MO.

255 HIGH AVE.

ST. LOUIS, MO. (CHURCH HILL)

67

36

JULY

HOWELL

GRANT

JAMES

43

2/2/1910

WHITE

MALE

U.S.A.

MARYLAND

TEXTILE MFG. CO.

NEWARK

ST. LOUIS, MO.

ST. LOUIS, MO.

HAGERSTOWN

MD.

ST. LOUIS, MO.

ST. LOUIS, MO.

W.D.W.

ST.

ST. LOUIS, MO. (CHURCH HILL) ST. LOUIS, MO. (CHURCH HILL) ST. LOUIS, MO. (CHURCH HILL)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10160

CERTIFICATE OF DEATH

10177

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last SUSIE HIVEN HULL		4. DATE OF DEATH Month Day Year July 25 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 30 1892
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Md. Clear Spring Wash Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Archibald McAllister		14. MOTHER'S MAIDEN NAME Emma guffacool	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Gilbert P. Hull		Address 425 Indiana Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic Cardio Vascular Disease With DUE TO (c) Cardiac Decompensation.		INTERVAL BETWEEN ONSET AND DEATH Few minutes Recent	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 14, 19 67, to July 25, 19 67, that (I) (we) last saw the deceased alive on July 24, 19 67, and that death occurred at 10:50 A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>[Signature]</i>		22b. DATE SIGNED 7-26-67	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Ditto, Jr.		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/27/67	
23c. NAME OF CEMETERY OR CREMATORY St Pauls Cemetery		23d. LOCATION (City or Town) (County) (State) Md. near Clear Spring Wash Co	
24. FUNERAL DIRECTOR Hagerstown Md Andrew K. Coffman Funeral Home Inc		25a. REC'D BY REGISTRAR JUL 31 1967	
25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

10160

STATEMENT OF DEATH

Deceased: *[illegible]*
Age: *[illegible]*
Sex: *[illegible]*
Race: *[illegible]*
Marital Status: *[illegible]*
Occupation: *[illegible]*

Place of Birth: *[illegible]*
Date of Birth: *[illegible]*

Place of Death: *[illegible]*
Date of Death: *[illegible]*
Cause of Death: *[illegible]*
Manner of Death: *[illegible]*

Signature of Physician: *[illegible]*
Signature of Coroner: *[illegible]*
Signature of Registrar: *[illegible]*

[Faint, mostly illegible text at the bottom of the page, possibly containing additional details or a signature block.]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10181

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10178

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NEW YORK b. COUNTY JEFFERSON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) INTERSTATE 70 I				d. STREET ADDRESS ADAMS CENTER			
3. NAME OF DECEASED (Type or print) First LOYAL Middle F. Last HURLEY				4. DATE OF DEATH Month JULY Day 24 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG. 23, 1886	9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINISTER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) GARWIN, IOWA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THEODORE S. HURLEY				14. MOTHER'S MAIDEN NAME EVA MAY DAVIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 105-28-8168		17. INFORMANT Address MILDRED L BURT ADAMS CENTER N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Compound skull fracture DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. XX		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-auto collision					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 noon 7/24 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Route 70 W. of Hancock, M	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Howard N. Weeks		M.D. HOWARD N. WEEKS, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		7/25/67 22. DATE SIGNED	
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		580 NORTHERN AVE.	
				Address (Street, city, town, or county)		HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 7/25/67		23c. NAME OF CEMETERY OR CREMATORY UNION CEMETERY,		23d. LOCATION (City or Town) (County) (State) ADAMS CENTER, JEFF. CO. N.Y.	
24. FUNERAL DIRECTOR ADDRESS CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR DATE JUL 31 1967		25b. REGISTRAR'S SIGNATURE Charles Juzge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please ~~insert~~ ^{insert} ~~insert~~ ^{insert} carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>16 Months</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Memorial Convalescent Hospital</u>		d. STREET ADDRESS <u>20 West Water St.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Elenora -- Itnyer</u>		4. DATE OF DEATH Month Day Year <u>July 24 19 67</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 18, 1886</u>
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Franklin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Shank</u>		14. MOTHER'S MAIDEN NAME <u>Annie Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-30-9740</u>	
17. INFORMANT <u>Ronald L. Itnyer, Hagerstown, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cute myocardial infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arterio-sclerotic heart disease</u> DUE TO (c) <u>Generalized arterio-sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 years.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Post-Pulmonary Tuberculosis - (arrested)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1930</u> to <u>7-24-1967</u> , that (I) (we) last saw the deceased alive on <u>May 24 1967</u> , and that death occurred at <u>1:15 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Walter H. Wishard</u>		22b. DATE SIGNED <u>7-25-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walter H. Wishard</u>		22d. ADDRESS <u>152 W. Main St. Hagerstown - Penna</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>July 27, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Smithsburg Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Smithsburg Wash. Md.</u>	
24. FUNERAL DIRECTOR <u>Minnich Funeral Home, Smithsburg, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUL 28 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

10183

CHARTER OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 5-63

<div style="display: flex; justify-content: space-between;"> <div> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div> <div> 10180 10180 </div> </div>											
1. PLACE OF DEATH e. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Boonsboro				c. LENGTH OF STAY IN 1b Aug. 26-1961		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore				d. STREET ADDRESS 4206 Loch Raven Blvd.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fahrney-Keedy Memorial Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Annie Jane Keen						4. DATE OF DEATH Month July Day 20 Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 4-1875		9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months 0 Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Alexander Kennedy						14. MOTHER'S MAIDEN NAME Sarah Chester					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. John R. Fogle				Address Same			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic - Cardio-vascular 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
2Da. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				2Db. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				2Dd. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		2Df. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from May 3, 1967 , to July 20, 1967 , that (I) (we) last saw the deceased alive on July 15, 1967 , and that death occurred at 2 P.M. from the causes and on the date stated above.											
22a. SIGNATURE G. W. LeVan						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/20/67			
22c. PHYSICIAN'S NAME (Type) G. W. LEVAN						22d. ADDRESS BOONSBORO, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-22-67		23c. NAME OF CEMETERY OR CREMATORY Oaklawn		23d. LOCATION (City, town or county) (State) Baltimore, Maryland					
24. FUNERAL DIRECTOR'S SIGNATURE Mitchell-Wiedefeld Home, Inc.						25a. REC'D BY REGISTRAR JUL 24 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			



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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10184

CERTIFICATE OF DEATH

10181

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 4 MOS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1833 WOODBURN DRIVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JENNIE Middle DREW Last KELLUM				4. DATE OF DEATH Month JULY Day 24 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/20/1888		9. AGE (In years as birthday) yrs. 78	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL P. TOWLER				14. MOTHER'S MAIDEN NAME MOLLIE SIXEAS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address HAGERSTOWN MD. MRS. MARY J. GARRIS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, recurrent 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) cerebral arteriosclerosis DUE TO (c) arteriosclerosis, general						INTERVAL BETWEEN ONSET AND DEATH unk. unk. unk.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensive cardiovascular disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) NO		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April , 19 67 , to 24 July , 19 67 , that (I) (we) last saw the deceased alive on 24 July 1967 , and that death occurred at 5:45 PM , from causes and on the date stated above.							
22a. SIGNATURE Cloris M. Snyder				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 25 July 67	
22c. PHYSICIAN'S NAME (Type) CLOVIS M. SNYDER M.D.				22d. ADDRESS 106 N. POTOMAC ST. HAGERSTOWN MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/26/67		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEM.		23d. LOCATION (City or Town) (County) (State) WASHINGTON D.C.	
24. FUNERAL DIRECTOR W. J. Korman, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUL 28 1967		25b. REGISTRAR'S SIGNATURE James J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10184

WILLIAM

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b D. O. A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 130 Ray St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Freddie Fahrney Knodle		4. DATE OF DEATH Month Day Year July 30, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 18, 1916
9. AGE (In years last birthday) 50 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 11 12	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Hauling		11b. KIND OF BUSINESS OR INDUSTRY Trucking	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Harvey H. Knodle		14. MOTHER'S MAIDEN NAME Ada V. Gorss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 219-05-2960	
17. INFORMANT Hagerstown, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Instant Recent	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		22. DATE SIGNED 7-31-67	
EXAMINER'S NAME (Type)		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-2-67	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery	23d. LOCATION (City or Town) (County) (State) Boonsboro, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR AUG 2 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

WATER-LOGGED SOILS

10122

WATER-LOGGED SOILS

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10186

CERTIFICATE OF DEATH

10183

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 51 EAST AVE.	
3. NAME OF DECEASED (Type or print) First SADA Middle PEARL Last KRAMER		4. DATE OF DEATH Month JULY Day 7 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/1887
9. AGE (In years birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME URIAH PALMER		14. MOTHER'S MAIDEN NAME MARY HESSONG	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. ESTHER CRAMER		HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Stomach DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 4 months 8 months
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 66 , 19 66 , to 7/7 , 19 67 , that (I) (we) last saw the deceased alive on 6/30 , 19 67 , and that death occurred at 2:04 A.M. from causes and on the date stated above.			
22a. SIGNATURE George Jennings		22b. DATE SIGNED 7/7/67	
22c. PHYSICIAN'S NAME (Type) George Jennings		22d. ADDRESS 318 N. Potomac St Hagerstown, Md.	
23a. BURIAL CREMATION, RETURN TO LAND	23b. DATE THEREOF 7/9/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEM.	23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.		25a. REC'D BY REGISTRAR JUL 11 1967	
25b. REGISTRAR'S SIGNATURE Juanes Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 43 YEARS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS 134 WEST WASHINGTON	
3. NAME OF DECEASED (Type or print) First JOHN Middle SCOTT Last LANTZ		4. DATE OF DEATH Month JULY Day 19 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 19, 1883
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED INSURANCE AGENT.		10b. KIND OF BUSINESS OR INDUSTRY INSURANCE BUSIN.	
11. BIRTHPLACE (County & State, or foreign country) AURORA, WEST VIRGINIA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN A. LANTZ		14. MOTHER'S MAIDEN NAME OLIVE SCHAEFFER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) NO		16. SOCIAL SECURITY NO. 217-32-5066	
17. INFORMANT MRS. LENORA GLADWIN,		Address 8 ROESSNER AVENUE, HAGERSTOWN, MARYLAND.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Brain Syndrome 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis DUE TO (c) Coronary Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 11 months 1 year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-5 , 19 66 , to 7-19 , 19 67 that (I) (we) saw the deceased alive on 7-19 , 19 67 , and that death occurred at 5:15 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dalton M. Welty		22b. DATE SIGNED JULY 21, 1967	
22c. PHYSICIAN'S NAME (Type) DALTON M. WELTY, M.D.		22d. ADDRESS 998 POTOMAC AVE. HAGERSTOWN, MARYLAND.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/22/67	23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.		25a. REC'D BY REGISTRAR DATE JUL 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

18101

DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT ATTORNEY GENERAL

STATE OF NEW YORK

IN SENATE

January 1, 1910

REPORT OF THE

COMMISSIONER OF HEALTH

FOR THE YEAR 1909

ALBANY: J.B. LIPPINCOTT & CO., 1910.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

10185
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10185

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY in lb 2 Weeks	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg 21.1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			d. STREET ADDRESS Bloody Lane		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Charles Middle Alburtus Last Lohman			4. DATE OF DEATH Month July Day 14 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1883	9. AGE (In years last birthday) yrs. 83	IF UNDER 1 YEAR Months 6 Days 20 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Park Service		11. BIRTHPLACE (County, State, or foreign country) Dec., Md.	
13. FATHER'S NAME August Lohman			14. MOTHER'S MAIDEN NAME Ida Moats		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 220-10-3752		17. INFORMANT Mrs. Charlotte Lohman, Sharpsburg, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) UREMIC ACIDOSIS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) RENAL FAILURE DUE TO (c) POSSIBLE MYOCARDIAL INFARCTION					INTERVAL BETWEEN ONSET AND DEATH 5 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE SENILE DETERIORATION					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/1 , 19 67 to 7/14 , 19 67 that (I) (was) last saw the deceased alive on 7/14 , 19 67 , and that death occurred at 4:30 M, from causes and on the date stated above.					
22a. SIGNATURE <i>Rizalito Amarillo</i>			22b. DATE SIGNED 7/16/67		22c. PHYSICIAN'S NAME (Type) RIZALITO AMARILLO
22d. ADDRESS SHARPSBURG, MD.			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-17-1967	23c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg, Md.
24. FUNERAL DIRECTOR John H. Bast, Jr., 112 N. Main St. Boonsboro, Md.			25a. REC'D BY REGISTRAR JUL 18 1967		
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

1018

CERTIFICATE OF SALE

First of March

Albany, N.Y.

Albany County, N.Y.

County

Town

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10189

10186

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN b. 6 Mos	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Coffman Home for the Aging		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last IDA MAE LUSHBAUGH		4. DATE OF DEATH Month Day Year July 26 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 12 1882
9. AGE (In years last birthday) 84 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Pa		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacob F. Bryan		14. MOTHER'S MAIDEN NAME Mary Alice Hysong	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-30-9095	
17. INFORMANT Roy E. Lushbaugh		Address 210 Phylane Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 Congestive heart failure DUE TO (b) arteriosclerotic cardiovascular disease DUE TO (c) years		INTERVAL BETWEEN ONSET AND DEATH sev. days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March , 19 62 , to July , 19 67 , that (I) (we) lost the deceased alive on July 24, 1967 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Howard N. Weeks		22b. DATE SIGNED 7/28/67	
22c. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22d. ADDRESS 580 Northern Avenue Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/29/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc		25a. REG'D BY REGISTRAR JUL 31 1967	
25b. REGISTRAR'S SIGNATURE [Signature]			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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10185

DEPARTMENT OF HEALTH

Washington
Hagerstown
Gallman, Rose for the Aging
IMA
People's House
Dorcasie

Mr. Alice Byrnes
200-30-30000, N. Washington 110 Byrnes Drive
Hagerstown, Md.

Andrew E. Gallman, Hagerstown, Md.
7/20/57
Hagerstown, Md.
Jul 21 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10190

CERTIFICATE OF DEATH

10187

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS St James Village	
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE VIRGINIA MAY		4. DATE OF DEATH Month Day Year July 11 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 13-1885
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John A. Roberts		14. MOTHER'S MAIDEN NAME Elizabeth Tobery	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. Not available	
17. INFORMANT Mrs. Wm. C. Main-		Address Rt. 3-Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arteriosclerosis DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 10 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/2/67 , 19__ to 7/11/67 , 19__, that (I) (we) lost the deceased on 7/10/67 , 19__, and that death occurred at 9:25 AM , from causes and on the date stated above.			
22a. SIGNATURE Robert V. Campbell M.D.		22b. DATE SIGNED 7/11/67	
22c. PHYSICIAN'S NAME (Type) Robert V. Campbell		22d. ADDRESS HAGERSTOWN Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF July 14-1967	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION (City or Town) (County) (State) Frederick, Md. 21701
24. FUNERAL DIRECTOR Frederick Md		25a. REC'D BY REGISTRAR M.R. Etchison and Son ADDRESS By Edward J. Whitman	
25b. REGISTRAR'S SIGNATURE Charles Jones		DATE JUL 13 1967	

1010

STATE OF OHIO

Washington County Hospital

Washington R. 3

St James Village

Washington County Hospital

May 11 1907

MAY

VIRGINIA

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10191

10183

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Canada b. COUNTY Toronto Gore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Hancock		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bolton, Ontario	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS Lot 16 Concession 10	
3. NAME OF DECEASED (Type or print) First Middle Last Sylvester Weare McGarvey		4. DATE OF DEATH Month Day Year July 24, 19 67	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1913
9. AGE (In years last birthday) yrs. 54		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) experimental		10b. KIND OF BUSINESS OR INDUSTRY aircraft mfg.	
11. BIRTHPLACE (State or foreign country) Wearton, Ont., Can.		12. CITIZEN OF WHAT COUNTRY? Canada	
13. FATHER'S NAME William McGarvey		14. MOTHER'S MAIDEN NAME Katherine McCartney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Matthew McGarvey, Toronto, Ont., Can.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-auto collision	
20c. TIME OF INJURY Month, Day, Year 12 noon 7/24 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Route 70 West of Hancock, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		7/26/67 22. DATE SIGNED	
ACTUAL SIGNATURE Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 7-26-67	
23c. NAME OF CEMETERY OR CREMATORY Toronto, Ont., Can.		23d. LOCATION (City or Town) (County) (State) Toronto, Ont., Can.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10192

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10189

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Canada b. COUNTY Toronto Gore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-Hancock		c. LENGTH OF STAY IN 1b 90.3	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bolton, Ontario		d. STREET ADDRESS Lot 16 Concession 10	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Vera Middle McGarvery Last McGarvery		4. DATE OF DEATH Month July Day 24 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1913
9. AGE (In years lost birthday) 54 yrs.		10. IF UNDER 1 YEAR Months 54 Days 54 Hours 54 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) S. Porcupine, Ont. Can		12. CITIZEN OF WHAT COUNTRY? Canada	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Matthew McGarvery, Toronto, Ont., Can.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured skull DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sudden DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto-auto collision	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 12 noon 7/24 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) (County) (State) Route 70 West of Hancock, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md.	
22. DATE SIGNED 7/26/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) removal		23b. DATE THEREOF 7-26-67	
23c. NAME OF CEMETERY OR CREMATORY Toronto, Ont., Can.		23d. LOCATION (City or Town) (County) (State) Toronto, Ont., Can.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUL 31 1967	
		25b. REGISTRAR'S SIGNATURE [Signature]	

0192

1944-1945

1944-1945

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1944-1945

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
10193					10190				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY Washington MARYLAND					a. STATE Maryland b. COUNTY Frederick				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural- Boonsboro					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Frederick				
c. LENGTH OF STAY IN lb 5 yrs.					d. STREET ADDRESS 211 W. Fifth Street				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Fahrney-Keedy Memorial Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Blanche					4. DATE OF DEATH Month 7 Day 9 Year 1967				
5. SEX Female					6. COLOR OR RACE White				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH 12/13/1881				
9. AGE (In years last birthday) 85 yrs.					IF UNDER 1 YEAR Months 86 Days 86 Hours 86 Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker					10b. KIND OF BUSINESS OR INDUSTRY None				
11. BIRTHPLACE (County & State, or foreign country) Frederick, Md.					12. CITIZEN OF WHAT COUNTRY? U. S.				
13. FATHER'S NAME Henry McHenry					14. MOTHER'S MAIDEN NAME Catherine Jane Crouse				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 213-24-9269				
17. INFORMANT Fahrney-Keedy Memorial Home					Address Boonsboro, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 years									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from July 7 , 19 67 , to July 9 , 19 67 , that (I) (we) last saw the deceased alive on July 7 , 19 67 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above.									
22a. SIGNATURE D. H. W. Sevan / M.L.S. M.D. 22b. DATE SIGNED 7-10-67									
22c. PHYSICIAN'S NAME (Type) D. H. W. Sevan / M.L.S. 22d. ADDRESS Boonsboro Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial									
23b. DATE THEREOF 7-11-1967									
23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery									
23d. LOCATION (City, town or county) (State) Frederick, Maryland									
24. FUNERAL DIRECTOR'S SIGNATURE Robert E. Dailey & Son ADDRESS Frederick, Maryland									
25a. REC'D BY REGISTRAR JUL 12 1967 25b. REGISTRAR'S SIGNATURE Charles Judge									

10198

Washington

Maryland

Frederick

Rural - Boonaboro

5 yrs.

Frederick

Patney-Keady Memorial Home

211 W. Fifth Street

Blanche

McHenry

9 27

Female white

12/13/1891

7 25

Frederick, Md.

U. S.

Blanche McHenry

Catherine Jane Cross

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10194

CERTIFICATE OF DEATH

10191

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal of the body in any event, within 72 hours of death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg Rural		c. LENGTH OF STAY IN 1b 2 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg rural		211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD 1				d. STREET ADDRESS RFD 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Drusilla Last Miller				4. DATE OF DEATH Month July Day 25 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1884		9. AGE (In years lost birthday) yrs. 82	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Foxville, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David C. Brown				14. MOTHER'S MAIDEN NAME Sarah A. Lumm			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 216-46-7677		17. INFORMANT Address Mrs. Alice Tracy, Smithsburg, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4221 IMMEDIATE CAUSE (a) Heart DUE TO myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial infarction DUE TO myocardial infarction (c) myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 4 days 1 1/2 hrs 15 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 21, 1967 to July 24, 1967 that (I) (we) lost saw the deceased alive on July 24, 1967 and that death occurred at M from causes and on the date stated above.							
22a. SIGNATURE Geo. A. Kohler M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED July 25, 1967	
22c. PHYSICIAN'S NAME (Type) Geo. A. Kohler				22d. ADDRESS Smithsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 28, 1967		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		23d. LOCATION (City or town) (County) (State) Smithsburg Wash. Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home				ADDRESS , Smithsburg, Md.		25a. REC'D BY REGISTRAR DATE JUL 28 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judger			

1111

STATE OF DEATH

DEPARTMENT OF HEALTH

DATE OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

MARRIAGE

CHILDREN

SMOKING

ALCOHOL

DRUGS

DIET

EXERCISE

STRESS

ENVIRONMENT

GENETICS

DATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10195

CERTIFICATE OF DEATH

10192

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. STREET ADDRESS 716 SUNSET AVE.	
3. NAME OF DECEASED (Type or print) First CHARLOTTE Middle VERONA Last MITCHELL		4. DATE OF DEATH Month JULY Day 30 Year 1967	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/6/1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 4 Days 7 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (County & State, or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MILLARD FILMORE REYNOLDS		14. MOTHER'S MAIDEN NAME JULIA A. HOFFMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT MRS. GAIL KERFOOT		Address FRONT ROYAL VA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MALIGNANT LYMPHOMA (RETICULUM CELL CARCOMA) 2000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertensiva cardiovascular disease			INTERVAL BETWEEN ONSET AND DEATH 4-7-67
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-7-67 , 19__, to 7-30-67 , 19__, that (I) (we) last saw the deceased alive on 7-30-67 , 19__, and that death occurred at 1:25A M, from causes and on the date stated above.			
22a. SIGNATURE <i>Sidney Novenstein</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 7-31-67
22c. PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN, M. D.		22d. ADDRESS FUNKSTOWN, MD.	
23a. BURIAL, CREMATION, REMOVAL BURIAL	23b. DATE THEREOF 8/1/67	23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. PARK	23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.
24. FUNERAL DIRECTOR <i>W. J. Norment</i>		25a. REC'D BY REGISTRAR DATE AUG 2 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10196

CERTIFICATE OF DEATH

10193

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Hagerstown</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joseph O. Moats</u>		4. DATE OF DEATH <u>July 15</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/17/1882</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Tilghmanton, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Moats</u>		14. MOTHER'S MAIDEN NAME <u>Rebecca Rohrer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>198-30-4769</u>	
17. INFORMANT <u>Mr. Carrie Moats-Hagerstown</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO <u>Arteriosclerotic cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Chronic</u> (b) <u>Chronic</u> (c) <u>Chronic</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>20 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>7/15</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>7/17/67</u> , and that death occurred at <u>11:50 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>W. C. Brewer</u>		22b. DATE SIGNED <u>7/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. C. Brewer</u>		22d. ADDRESS <u>Greencastle, Penna.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>7/18/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Reitt Ch. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>near Carlisle, Md.</u>	
24. FUNERAL DIRECTOR <u>A. E. Minnich - Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>JUL 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL					d. STREET ADDRESS 134 W. WASHINGTON ST.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First FRANCES Middle VIRGINIA Last MUMMERT					4. DATE OF DEATH Month JULY Day 25 Year 1967				
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/21/1911		9. AGE (In years last birthday) 55 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CASHIER		10b. KIND OF BUSINESS OR INDUSTRY LIFE INSURANCE CO.		11. BIRTHPLACE (County & State, or foreign country) MARYLAND			12. CITIZEN OF WHAT COUNTRY U.S.A.		
13. FATHER'S NAME CLARENCE GRUBER					14. MOTHER'S MAIDEN NAME EDITH MYERS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-30-5563		17. INFORMANT MR. LOREN R. MUMMERT			Address HAGERSTOWN MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of Breast 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									INTERVAL BETWEEN ONSET AND DEATH 5 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 10/27 , 19 67 , to 7/25 , 19 67 , that (I) (we) last saw the deceased alive on 7/25 , 19 67 , and that death occurred at 9:15 AM , from causes and on the date stated above.									
22a. SIGNATURE Donald E. Martin					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7/27/67		
22c. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.					22d. ADDRESS 418 N. Potomac St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Type)		23b. DATE THEREOF 7/28/67		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			23d. LOCATION (City or town) (County) (State) HAGERSTOWN WASH. MD.		
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.					25a. REC'D BY REGISTRAR DATE JUL 31 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones		

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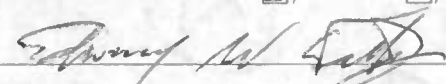
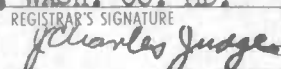
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10198

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10195

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b LIFE			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 144 NORTH CANNON AVENUE				d. STREET ADDRESS 144 NORTH CANNON AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GUY Middle CHARLES Last MUSEY				4. DATE OF DEATH Month JULY Day 19 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 16, 1912		9. AGE (In years lost birthday) yrs. 54	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OWNER		10b. KIND OF BUSINESS OR INDUSTRY GROCERY STORE		11. BIRTHPLACE (State or foreign country) HAGERSTOWN, MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JACOB E. MUSEY				14. MOTHER'S MAIDEN NAME CLARA BELLE WHITE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. (If yes give war or dates of service) ***** 218-30-9758		17. INFORMANT MRS. NORMA S. MUSEY, 144 North Cannon Avenue, HAGERSTOWN, MARYLAND.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH Instant Recent
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE 		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		7/21/67	
EXAMINER'S NAME (Type) EDWARD W. DITTO, JR. M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		215 W. WASHINGTON ST. HAGERSTOWN, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/22/67		23c. NAME OF CEMETERY OR CREMATORY REST HAVEN CEMETERY		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, WASH. CO. MD.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR DATE JUL 25 1967		25b. REGISTRAR'S SIGNATURE 	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10199

CERTIFICATE OF DEATH

10196

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Pa. b. COUNTY Franklin			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 9 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waynesboro Pa. 75.3			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS 17 N. Broad St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Charles Middle Anthony Last Noel				4. DATE OF DEATH Month July Day 19 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1892		9. AGE (In years last birthday) 74 yrs.	10. IF UNDER 1 YEAR Months 7 Days 19	11. IF UNDER 24 HRS. Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Waynesboro Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Louis Noel				14. MOTHER'S MAIDEN NAME Emma Brockley			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 9/15/18 to 11/25/18		16. SOCIAL SECURITY NO. 179-36-3201		17. INFORMANT Address Miss Gertrude C. Noel, Waynesboro Pa.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) atherosclerotic vas. disease DUE TO (c) hypertension						INTERVAL BETWEEN ONSET AND DEATH 8-10 days hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pneumonia & diabetes						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May , 19 67 , to July 19 , 19 67 , that (I) (we) last saw the deceased alive on July 19 , 19 67 , and that death occurred at 6:30 M., from causes and on the date stated above.							
22a. SIGNATURE H.N. WEEKS				22b. DATE SIGNED 7/20/67		22c. PHYSICIAN'S NAME (Type) H.N. WEEKS	
22d. ADDRESS 580 Northern A Hagerstown, Md.				22e. REC'D BY REGISTRAR 21 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/22/67		23c. NAME OF CEMETERY OR CREMATORY St. Andrews		23d. LOCATION (City or Town) (County) (State) Waynesboro Franklin Pa.	
24. FUNERAL DIRECTOR Kalter Z. Hare				25a. REGISTRAR'S SIGNATURE Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

10197

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pennsylvania</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Six Weeks</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Avalon Manor Inc. Marsh Pike</u>		d. STREET ADDRESS <u>8 Hill Crest Ave.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Be ssie Rowe Null</u>		4. DATE OF DEATH Month Day Year <u>July 17 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/17/1884</u>
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George W. Rowe</u>		14. MOTHER'S MAIDEN NAME <u>Frances M. Flenner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>H. Richard Null,</u>		Address <u>34 Hill Crest Ave. Waynesboro Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Arteriosclerosis - Generalized</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>YR.</u> <u>YR.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 12, 1967</u> to <u>July 17, 1967</u> , that (I) (we) last saw the deceased alive on <u>July 17, 1967</u> and that death occurred at <u>2:00 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Charles A. Hoffman</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22b. DATE SIGNED <u>7/15/67</u>	
22d. ADDRESS <u>214 N. Potomac St - Hagerstown</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>Waynesboro, Franklin, Pa.</u>	
24. FUNERAL DIRECTOR <u>Walter Z. Grove</u>		ADDRESS <u>Waynesboro, Pa.</u>	
25a. REC'D BY REGISTRAR <u>JUL 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

0052

1947

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10201

CERTIFICATE OF DEATH

10198

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Mt. Lena Rd.			
3. NAME OF DECEASED (Type or print) First Charles Middle Edward Last Paden				4. DATE OF DEATH Month July , Day 1 , Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1907	9. AGE (In years last birthday) yrs. 60	IF UNDER 1 YEAR Months 3 Days 29		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance			10b. KIND OF BUSINESS OR INDUSTRY Air Craft		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME William Paden				14. MOTHER'S MAIDEN NAME Daisy Trovinger			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.			16. SOCIAL SECURITY NO. 		17. INFORMANT Mrs. Ruth Paden, Rfd. 1 Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH less than 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gastrointestinal Bleeding							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 			20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21. I certify that (1) (this hospital) attended the deceased from Jan 1965 to July 1, 1967 , that (1) (we) last saw the deceased alive on July 1, 1967 , and that death occurred at 8:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE M. E. Byrkit				22b. DATE SIGNED 6-3-67		22c. PHYSICIAN'S NAME (Type) Will: amsport Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-5-67		23c. NAME OF CEMETERY OR CREMATORY Pleasant Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Sandy Mount, Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR JUL 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATEMENT OF WORK

1960

1. General Information

2. Objectives

3. Methods

4. Results

5. Conclusions

6. References

7. Appendix

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57. Bibliography

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10202

CERTIFICATE OF DEATH

10199

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 1			c. LENGTH OF STAY IN 1b 4 DAYS			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS HANCOCK		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARY Middle VIOLA Last PERCY				4. DATE OF DEATH Month 7 Day 24 Year 1967			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9.2.1894		9. AGE (In years last birthday) yrs. 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BARNHILL OHIO		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM E MILLER				14. MOTHER'S MAIDEN NAME SARAH GARABRANDT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address ROBERT PERCY RURAL 1 HANCOCK MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke 4200 DUE TO ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Gen Arteriosclerosis (c) Gen Arteriosclerosis						INTERVAL BETWEEN ONSET AND DEATH 10 min 10 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Bronchitis						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HDW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6/15/67 , 19 67 , to 11/1 , 19 66 , that (I) (we) last saw the deceased alive on 11/1 , 19 66 , and that death occurred at 10:30AM , from causes and on the date stated above.							
22a. SIGNATURE FB Thomas III M.D.				22b. DATE SIGNED 7/24/67		22c. PHYSICIAN'S NAME (Type) FB Thomas III M.D.	
22d. ADDRESS Hancock, Md.				22e. REC'D BY REGISTRAR DATE JUL 28 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7.28.67		23c. NAME OF CEMETERY OR CREMATORY E.AVE. NEW PHILLA CEM.		23d. LOCATION (City or Town) (County) (State) E.AVE. NEW PHILLA OHIO	
24. FUNERAL DIRECTOR Hansel & Shawe Hancock Md				25b. REGISTRAR'S SIGNATURE Charles Jones			

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

52202

CERTIFICATE OF DEATH

WASHINGTON

MARYLAND

WASHINGTON

RURAL

8 DAYS

RURAL

HANDOOK

PERCY

VIOLE

MARY

22

1898

X

8

7

U.S.A.

BARRETT OHIO

HOUSEWIFE

SARAH GARRANT

WILLIAM MILLER

ROBERT PERCY RURAL 1 HANGCOCK MD.

NO

Handwritten notes:
25th
April
1898
Barrett
Housewife
Miller

BURIAL 1898. 22. VIOLE PERCY RURAL 1 HANGCOCK MD.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10203

10200

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Lantz d. STREET ADDRESS RD 1					
3. NAME OF DECEASED (Type or print) Harvey E. Pryor				4. DATE OF DEATH Month July Day 7 Year 19 67					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1891		9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Machine Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Pryor				14. MOTHER'S MAIDEN NAME Amanda Brown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 213-10-7073				17. INFORMANT Address Emma G. Pryor Lantz, Md. RD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardiovascular disease (c) 4321 (e), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH 7 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. _____ 19____	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 3-24, 1967 to 7-7 , 1967, that (I) (we) last saw the deceased alive on 7-7 , 1967, and that death occurred at 3:45 PM, from the causes and on the date stated above.			
22a. SIGNATURE Charles F. Hess				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 7-7-67		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Charles F. Hess, M.D.				22d. ADDRESS Smithsburg, Maryland 21783					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-10-67		23c. NAME OF CEMETERY OR CREMATORY Germantown Ch. of God		23d. LOCATION (City, town or county) (State) Cascade Md. Fred. Co			
24 FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager				25a. REC'D BY REGISTRAR JUL 10 1967					
ADDRESS Thurmont, Md.				25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

CERTIFICATE OF DEATH

1203

Residence

Occupation

Place and date of death

Signature of physician

Sex

Age

Medical history

Cause of death

21-10-1917

Cerebral thrombosis

Arteriosclerotic cardiovascular disease

9-12-1917

1917

1917

1917-18

1917-18

1917-18

1917-18

1917-18

1917-18

1917-18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 52 Wayside Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Glen First Grove Middle Rebok Last 4. DATE OF DEATH July 10, 1967 Month July 10, Day 19 67 Year						5. SEX male 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 3-11-96 9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) aircraft mfg. 10b. KIND OF BUSINESS OR INDUSTRY aircraft mfg. 11. BIRTHPLACE (County & State, or foreign country) Franklin Co., Penna. 12. CITIZEN OF WHAT COUNTRY?						13. FATHER'S NAME Unknown 14. MOTHER'S MAIDEN NAME Unknown 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes 16. SOCIAL SECURITY NO. 155-01-0844 17. INFORMANT Glen G. Rebok, Jr., Aurora, Ill Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL THROMBOSUS 4200 DUO TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) UNKNOWN DOE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 11 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from 07/01/67 19 , that (I) (we) last saw the deceased alive on 07/10/67 19 , and that death occurred at 1:55 PM 07/10/67 M, from the causes and on the date stated above.													
22a. SIGNATURE 22b. DATE SIGNED 07/11/67 22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN M.D. 22d. ADDRESS CLEARSPRING, MARYLAND ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>													
23a. BURIAL, CREMATION, REMOVAL (Specify) burial 23b. DATE THEREOF 7-14-67 23c. NAME OF CEMETERY OR CREMATORY Gettysburg Nat. Cem. 23d. LOCATION (City, town or county) (State) Gettysburg, Penna.													
24. FUNERAL DIRECTOR ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE Minnich Funeral Home, Hagerstown, Md. JUL 13 1967													

11 DAYS
UNKNOWN

CEREBRAL THROMBOSIS
ARTERIOSCLEROTIC HEART DISEASE

NONE

07/10/67 1:55 PM

07/10/67

07/11/67

ARCHIE ROBERT COHEN M.D. CLEARSPRING, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10205

CERTIFICATE OF DEATH

10202

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>			d. STREET ADDRESS <u>424 Mitchell Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Frankie</u> Middle <u>Lynn</u> Last <u>Ricker</u>			4. DATE OF DEATH Month <u>July</u> Day <u>5</u> Year <u>1967</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1967</u>		9. AGE (In years lost birthday) yrs. <u>3</u> <u>54</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>	
13. FATHER'S NAME <u>Richard Lee Ricker</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. R.L. Ricker</u> Address <u>424 Mitchell Ave. Hagerstown, Md.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 7735 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PREMATURITY</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <u>4 Hours</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>4 July</u> , 19 <u>67</u> , to <u>5 July</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>5 July</u> 19 <u>67</u> , and that death occurred at <u>2 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>6 July 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. N. FENDER</u>		22d. ADDRESS <u>210 N. Potomac St. Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/6/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Hagerstown Washington Md</u>		24. FUNERAL DIRECTOR <u>Wm. G. Hook</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>			
25a. REC'D BY REGISTRAR <u>JUL 10 1967</u>		25b. REGISTRAR SIGNATURE <u>[Signature]</u>			

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Washington

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Washington (letter to Mr. Tolson)

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Washington (letter to Mr. Tolson)

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to

Washington (letter to Mr. Tolson)

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Washington (letter to Mr. Tolson)

W. A. Rosten

see above for details of investigation

not shown to agent

Washington

July 1, 1967

July 1, 1967

July 1, 1967

July 1, 1967

July 1, 1967

Washington

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Washington

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10206

CERTIFICATE OF DEATH

10203

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u> 21, 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maugansville, MD</u>		d. STREET ADDRESS <u>216 North St</u>	
3. NAME OF DECEASED (Type or print) <u>Jacob H. Risser</u>		4. DATE OF DEATH <u>July 8, 1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb-13 1880</u>
9. AGE (In years last birthday) <u>87</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Risser</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Martin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-18-1939</u>	
17. INFORMANT <u>Anna Risser - Maugansville</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>10 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid Arthritis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/4</u> , 19 <u>65</u> to <u>7/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6/30</u> , 19 <u>67</u> , and that death occurred at <u>10:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Donald E. Martin</u> M.D.		22b. DATE SIGNED <u>7/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Donald E. Martin, M.D.</u>		22d. ADDRESS <u>218 N. Potomac St., Htg, Wash, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>7/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Reiff Ch. Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>near Clearfax, Md.</u>	
24. FUNERAL DIRECTOR <u>A. E. Munnich - Greencastle</u>		25a. REC'D BY REGISTRAR <u>JUL 13 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE	

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UNITED STATES DEPARTMENT OF THE INTERIOR

WASHINGTON, D. C.

TO THE SECRETARY OF THE INTERIOR

FOR THE YEAR 1900

AND FOR THE YEAR 1901

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AND FOR THE YEAR 1913

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10207

CERTIFICATE OF DEATH

10204

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. STREET ADDRESS XXXX RD. BOONSBORO, MD.			
3. NAME OF DECEASED (Type or print) First BESSIE Middle SOUTH Last ROUTZAHN				4. DATE OF DEATH Month JULY Day 11 Year 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/5/1882	9. AGE (In years last birthday) 85 yrs.	IF UNDER 1 YEAR Months 1 Days 6		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON Co., Md		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME BENJAMIN GEARY SOUTH			14. MOTHER'S MAIDEN NAME JANE C ADAMS				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-48-5623		17. INFORMANT ISABELLE A. GEHR Address HAGERSTOWN, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Transverse Colon DUE TO (b) Metastases to liver DUE TO (c) Intestinal Obstruction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH 1 yr 6 mo 1 wk
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 6, 1967 , to July 11, 1967 , that (I) (we) last saw the deceased alive on July 11, 1967 , and that death occurred at 5:30 A.M. from causes and on the date stated above.							
22a. SIGNATURE John A. Moran M.D.			22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) JOHN A. MORAN M.D.		
22d. ADDRESS HAGERSTOWN, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/14/67		23c. NAME OF CEMETERY OR CREMATORY BEAVER CREEK CEMETERY		23d. LOCATION (City or Town) (County) (State) BEAVER CREEK WASH. MD.	
24. FUNERAL DIRECTOR HOWARD J. GROVE				25a. REC'D BY REGISTRAR HANCOCK, MARYLAND		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

10207

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MARYLAND

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GREENSBORO

WASHINGTON

XXXXX RD. GREENSBORO, NC.

WASHINGTON COUNTY HOSPITAL

JULY 11

ROUTINE

SOUTH

REBORN

07/11/88

X

FEMALE WHITE

WASHINGTON CO., NC.

HUSBAND

JANE C. ADAMS

BENJAMIN DEARY SOUTH

517-2623 Y ISABELLE A. DEARY, HAGERSTOWN, MD.

HAGERSTOWN, MARYLAND

JOHN A. DEARY, D.

DEARY, JOHN A. DEARY, D. DEARY, JOHN A. DEARY, D.

HAGERSTOWN, MARYLAND

DEARY, JOHN A. DEARY, D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10208

CERTIFICATE OF DEATH

10205

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Md.		c. LENGTH OF STAY IN 1b 211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mill St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Nellie Middle Emma Last Routzahn		4. DATE OF DEATH Month July Day 10 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 1, 1906
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months 60 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Home duties	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Wolfkill		14. MOTHER'S MAIDEN NAME Lula Grossnickle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Willis Routzahn		Address Clear Spring, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Infarction DUE TO (c) Coronary artery atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 minutes 5 minutes Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 07/18/66 , 19__, to 07/10/66 , 19__, that (I) (we) last saw the deceased alive on 07/10/66 , 19__, and that death occurred on 4:30A.M. from causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i>		22b. DATE SIGNED 07/11/67	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen M.D.		22d. ADDRESS Clear Spring, Maryland 21722	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7/12/67	23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cem.	23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.
24. FUNERAL DIRECTOR <i>Margaret Rowland</i>		25a. REC'D BY REGISTRAR JUL 13 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE Clear Spring, Md.	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10209

10206

1. PLACE OF DEATH o. COUNTY Washington MARYLAND c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 629 Pennsylvania Ave.						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown 211 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)													
First Sonta		Middle Lorraine		Last Schaff		4. DATE OF DEATH		Month July Day 8 Year 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		B. OATE OF BIRTH March 18, 1905		9. AGE (In years last birthday) yrs. 62		IE UNDER 1 YEAR Months Days Hours Min.		IE UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Musician				10b. KIND OF BUSINESS OR INDUSTRY Entertainment		11. BIRTHPLACE (State or foreign country) Upton, Penna.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Harris Schaff						14. MOTHER'S MAIÖEN NAME Sarah Spielman							
IS WAS DECESSED EVER IN U.S. ARMEO FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 217-10-3447		17. INFORMANT Philip L. Schaff				Address: Hagerstown, Md. 629 Pennsylvania Ave.			
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic heart disease (c)												INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic alcoholism												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined manner <input type="checkbox"/>.													
ACTIONL SIGNATURE EXAMINER'S NAME (Type) Howard N. Weeks, M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEICAI EXAMINER <input type="checkbox"/> OEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 580 Northern Ave. Address (Street, city, town, or county) Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVA (Specify) Burial				23b. DATE THEREOF 7/12/67		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City or Town) (County) (State) Hagerstown, Washington, Md.			
24. FUNERAL DIRECTOR Wm. G. Host Rest Haven Funeral Chapel Hagerstown, Md.						25a. REC'D BY REGISTRAR DATE JUL 12 1967				25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10210

CERTIFICATE OF DEATH

10207

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 38 YEARS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D.O.A. WASHINGTON CO. HOSPITAL			d. STREET ADDRESS ROOM 202 HAMILTON HOTEL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First RUDOLPH Middle ADOLPH Last SCHULTZ			4. DATE OF DEATH Month JULY Day 7 Year 1967		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 28, 1885	9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHEF		10b. KIND OF BUSINESS OR INDUSTRY HOTEL BUSINESS		11. BIRTHPLACE (County & State, or foreign country) VOLYNIA, RUSSIA	
13. FATHER'S NAME RINEHART SCHULTZ			14. MOTHER'S MAIDEN NAME WIELAHMENIA CROSER		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO ***		16. SOCIAL SECURITY NO. 214-09-2263A	17. INFORMANT MR. ALVIN KRAUSE, QUAKERTOWN, PENNSYLVANIA		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarct 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes and obesity					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. none 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Dec , 19 62 , to July , 19 67 , that (I) (we) last saw the deceased alive on June 21 19 67 , and that death occurred at A.M. from causes and on the date stated above.					
22a. SIGNATURE Harold R. Tritch			22b. DATE SIGNED JULY 10, 1967		22c. PHYSICIAN'S NAME (Type) HAROLD R. TRITCH, JR. M.D.
22d. ADDRESS 302 N. POTOMAC ST. HAGERSTOWN, MD.			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/13/67	23c. NAME OF CEMETERY OR CREMATORY KELLERS CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) KELLERS CHURCH, BUCKS CO. PA.	
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.			25a. REC'D BY REGISTRAR JUL 14 1967		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certificates. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY in 1b 10 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Hagerstown d. STREET ADDRESS RFD 4 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frances Middle Violet Last Sheppard		4. DATE OF DEATH Month July Day 4 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-20-02
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 6 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Albert H. Middlekauff		14. MOTHER'S MAIDEN NAME Virgie Hoch	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-9109B	
17. INFORMANT Carl H. Sheppard, Hagerstown, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 492X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral Arterio-Sclerosis. Hypertension. Coronary Artery Disease. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 wks.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from July 14, 1967 to July 4, 1967 that (I) (we) last saw the deceased alive on July 4, 1967 and that death occurred at 4 A.M. from causes and on the date stated above.			
22a. SIGNATURE J.H. Beachley		22b. DATE SIGNED July 4, 1967	
22c. PHYSICIAN'S NAME (Type) J.H. Beachley		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE THEREOF 7-6-67	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.		25a. REC'D BY REGISTRAR JUL 6 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE James J. Jones	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10212

CERTIFICATE OF DEATH

10209

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wash</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>				c. LENGTH OF STAY IN It			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Home wood Church Home Inc</u>				d. STREET ADDRESS <u>Nore</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>L.</u> Last <u>Shirk</u>				4. DATE OF DEATH Month <u>July</u> Day <u>20</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 6, 1880</u>		9. AGE (In years last birthday) <u>86</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Big Pool Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John P. Murray</u>				14. MOTHER'S MAIDEN NAME <u>Delilah Tedrick</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-36-6037A</u>		17. INFORMANT <u>Mark & Wagner, Lpt, Wmst, 21795</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Coronary Occlusion</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Hypertensive C V Dis</u> DUE TO (b) <u> </u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u> <u>8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>65</u> , to <u>July 20</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>July 13</u> , 19 <u>67</u> , and that death occurred at <u>4 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert P. Conrad</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-20-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad</u>				22d. ADDRESS <u>Hagerstown, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7-23-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shakktown Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Big Pool, Md.</u>	
24. FUNERAL DIRECTOR <u>Minnich Funeral Home, Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>JUL 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

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COMMUNITY OF BIRTH

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Home and Church Home Inc

Gettysburg

Shirk

Wd 6, 1880 84

Domestic Housewife

Delia L. Tedrick

25-36-1037A Washington, D.C.

Carroll County, Maryland

Apprentice C.V. Miller

Robert P. Conrad

Robert P. Conrad

Chapman, Inc.

7-17-61 - Washington Community

Union General Home, Washington, D.C.

1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10213

CERTIFICATE OF DEATH

10210

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY in 1b 2 YEARS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MARTIN MANOR NURSING HOME				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BIG POOL			
				d. STREET ADDRESS BIG POOL			
				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FRANK Middle OTHO Last SHIVES				4. DATE OF DEATH Month JULY Day 23 Year 67			
5. SEX WHITE	6. COLOR OR RACE MALE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/1890	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STORE CLERK		10b. KIND OF BUSINESS OR INDUSTRY GOVERNMENT		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS W. SHIVES				14. MOTHER'S MAIDEN NAME SUSAN ISABELLE BEARD			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-16-3413		17. INFORMANT Address MR. EARL SHIVES BIG POOL, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Unknown							INTERVAL BETWEEN ONSET OF DEATH 92 hrs. unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 22 , 19 67 , to July 23 , 19 67 , that (I) (we) last saw the deceased alive on July 23 , 19 67 , and that death occurred at 4:50 PM from causes and on the date stated above.							
22a. SIGNATURE <i>William T. Layman</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) William T. Layman,				22d. ADDRESS 100 Professional Arts Building Hagerstown, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/25/67		23c. NAME OF CEMETERY OR CREMATORY PARKHEAD E.U.B.		23d. LOCATION (City or Town) (County) (State) BIG POOL WASH., MD.	
24. FUNERAL DIRECTOR <i>Howard F. Stone Hagerstown Md.</i>				25a. REC'D BY REGISTRAR DATE JUL 28 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Jones</i>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10214

10211

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wagers town</u>		c. LENGTH OF STAY in lb <u>-</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Chambersburg</u>		d. STREET ADDRESS <u>RD8 - Chambersburg</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>HIRAM E. SHUPP</u>		4. DATE OF DEATH Month Day Year <u>July 17 1967</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 7 1874</u>
9. AGE (In years last birthday) <u>92</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Arm</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Clearyspring, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Daniel Shupp</u>		14. MOTHER'S MAIDEN NAME <u>Saville Weller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>201-18-1654</u>	
17. INFORMANT <u>Mrs. Getz White - Chambersburg</u>		Address <u>RD8</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis cardiovascular</u> DUE TO (c) <u>disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1965</u> , 19 <u>67</u> , to <u>7/17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>7/17</u> , 19 <u>67</u> , and that death occurred at <u>3:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Wm C. Brewer</u>		22b. DATE SIGNED <u>7/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm C. Brewer</u>		22d. ADDRESS <u>Greencastle, Pa.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Reiff Ch. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Cearfoss Md.</u>	
24. FUNERAL DIRECTOR <u>A.E. Mennich</u>		25. REC'D BY REGISTRAR <u>JUL 20 1967</u>	
ADDRESS <u>Greencastle, Pa.</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>	

UNITED STATES DEPARTMENT OF AGRICULTURE

1954

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10215

CERTIFICATE OF DEATH

10212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 1 DAY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS WASHINGTON			
3. NAME OF DECEASED (Type or print) First DIANE Middle MARIE Last SINNER				4. DATE OF DEATH Month JULY Day 8 Year 19 67			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 7, 1967		9. AGE (In years last birthday) *** yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MARYLAND.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STEWART L. SINNER				14. MOTHER'S MAIDEN NAME DORIS CEARPOSS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. N/A		17. INFORMANT 5544 ALLEY DRIVE MR. STEWARD L. SINNER, HAGERSTOWN, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7735 IMMEDIATE CAUSE (a) Respiratory distress Syndrome DUE TO Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH none	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from July 7, 1967 , to July 8, 1967 , that (I) (we) last saw the deceased alive on July 8, 1967 , and that death occurred at 1:30 PM , from causes on and on the date stated above.							
22a. SIGNATURE Harold H. Gist				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED JULY 10, 1967	
22c. PHYSICIAN'S NAME (Type) HAROLD H. GIST, M.D.				22d. ADDRESS 214 N. POTOMAC ST. HAGERSTOWN, MARYLAND.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/11/67	23c. NAME OF CEMETERY OR CREMATORY MT. TABOR LUTH. CHURCH CEM.		23d. LOCATION (City or Town) (County) (State) RURAL HAGERSTOWN, WASH. CO.		
24. FUNERAL DIRECTOR CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.				25a. REC'D BY REGISTRAR JUL 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge MD.	

21322

INSTITUTE OF DESIGN

Propaganda Bureau -
P. 1000 - 1000

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10216

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10213

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b 1 Week		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Rohrsersville 211		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 79 Washington County Hospital				d. STREET ADDRESS Rfd. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Garley Middle Roosevelt Last Smith				4. DATE OF DEATH Month July Day 3 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH July 4, 1902		9. AGE (In years last birthday) yrs. 64	IF UNDER 1 YEAR Months 11 Days 29	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor		10b. KIND OF BUSINESS OR INDUSTRY Co. Road Dept.		11. BIRTHPLACE (County & State, or foreign country) Rural Rohrsersville, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George E. Smith				14. MOTHER'S MAIDEN NAME Emma Seigler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No.		16. SOCIAL SECURITY NO. 213-12-7222		17. INFORMANT Address Md. Mrs. Clara M. Smith, Rfd. 1 Rohrsersville,			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5610 antenatal obstruct DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) miscellaneous trauma DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH two days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) fatal bronchopneumonia & gastric ulcer							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE [Signature]		M.D. [Signature]		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) H.N. Weeks M.D.		22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-6-67		23c. NAME OF CEMETERY OR CREMATORY Locust Grove Cemetery		23d. LOCATION (City or Town) (County) (State) Locust Grove, Wash. Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REG'D BY REGISTRAR JUL 7 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10217

CERTIFICATE OF DEATH

10214

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN IB 2 WEEKS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK d. STREET ADDRESS RFD #2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last IRA SAMUEL SMITH			4. DATE OF DEATH Month Day Year JULY 22 19 67		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/25/1876	9. AGE (In years last birthday) 90	IF UNDER 1 YEAR Months Days Hours Min. 19 67
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXX FARMING		10b. KIND OF BUSINESS OR INDUSTRY FARM		11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA	
13. FATHER'S NAME PHILLIP SAMUEL SMITH			14. MOTHER'S MAIDEN NAME MARTHA MORGAN		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 182-40-5270		17. INFORMANT ROSA E. SMITH, RFD #2, HANCOCK, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Diabetic gangrene 2nd + 3rd left toes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>7 weeks</u> <u>4 yrs</u> <u>1 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis; senility</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 10th</u> , 19 <u>67</u> , to <u>July 22</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 22</u> , 19 <u>67</u> , and that death occurred at <u>6:30 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>John A. Moran</u>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 7/25/67	23c. NAME OF CEMETERY OR LOCATION ANTIOCH CHRISTIAN		23d. LOCATION (City or Town) (County) (State) FULTON CO; PENNSYLVANIA	
24. FUNERAL DIRECTOR <u>Harold J. Heine Hagerstown Md</u>		25a. REC'D BY REGISTRAR DATE JUL 28 1967		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

10011

WASHINGTON

MARYLAND

WASHINGTON

WAGGON

RURAL

2 WEEKS

WASHINGTON

RED 55

WASHINGTON COUNTY HOSPITAL

JULY

SMITH

SAMUEL

IRA

10/25/1958

MALE WHITE

U.S.A.

PENNSYLVANIA

FARM

EXX FARMING

MARTHA MORAN

PHILIP SAMUEL SMITH

155-40-2550 ROSA E. SMITH, RED 55, KANOOK, MO.

XXXXX

PENNSYLVANIA

MARTHA MORAN

10/25/58

BURIAL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

10218

10216

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport		c. LENGTH OF STAY IN 1b 9 Mos		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home Inc				d. STREET ADDRESS 306 Turnbridge Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last BERTHA G SPENCE				4. DATE OF DEATH Month Day Year July 9 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct 30 1890	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore City Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Davis Barner				14. MOTHER'S MAIDEN NAME Elizabeth Anne Roemer			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-30-6232		17. INFORMANT Address Mark G. wagner 2750 Virginia Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1992 Generalized Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)				18. CAUSE OF DEATH (Continued) Williamsport Md. 21795		INTERVAL BETWEEN ONSET AND DEATH 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 14 1966 to 7-9 1967 that (I) (we) last saw the deceased alive on 7-6 1967 , and that death occurred at 10 P.M. from causes and on the date stated above.							
22a. SIGNATURE Robert P. Conrad				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-10-67	
22c. PHYSICIAN'S NAME (Type) Robert P. Conrad				22d. ADDRESS Hagers town, Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/13/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore City Md.	
24. FUNERAL DIRECTOR Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR JUL 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items 8 & 9 Film 3390 7/17/67 kk

CERTIFICATE OF DEATH

10219

10217

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b 24 hrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Md.		21/1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital		d. STREET ADDRESS Rural 2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Daisy Reed Steele		4. DATE OF DEATH July 7 19 67	
5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/5/1893 9. AGE (In years last birthday) 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Duties		10b. KIND OF BUSINESS OR INDUSTRY House work	
11. BIRTHPLACE (County & State, or foreign country) Unknown		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-54-3623T	
17. INFORMANT Daniel Reed Address Hancock, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) prob. myocardial infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) coronary insufficiency DUE TO (c) generalized arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) emphysema		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5 July , 19 67 , to death , 19 67 , that (I) (we) last saw the deceased alive on 7 July , 19 67 , and that death occurred at 7 M, from causes and on the date stated above.			
22a. SIGNATURE John C. Steele		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7/10/67	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cem.		23d. LOCATION (City or Town) (County) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR Margaret Rowland		25a. REC'D BY REGISTRAR Charles Judge	
25b. REGISTRAR'S SIGNATURE		DATE JUL 11 1967	

10018

Washington, D.C. 20540
Department of Health, Education & Welfare
Bureau of Census
Washington, D.C. 20540
Mr. J. Edgar Hoover
Federal Bureau of Investigation
Washington, D.C. 20535
Dear Sir:

Enclosed for you are two copies of a report titled "The Census Bureau's Survey of the Public's Attitudes Toward the Federal Government". This report was prepared by the Social Science Research Center, which is a part of the Bureau of Census. It contains information on the public's views on the federal government, its role, and its performance. The report was prepared in response to a request from the President's Council on the Quality of Government Performance.

Very truly yours,
Director

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10220

10218

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN IT <u>2 MONTHS</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>WASH. County Hospital</u>		d. STREET ADDRESS <u>FAIRPLAY R. 1</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>TAMMY SUE STEVENS</u>		4. DATE OF DEATH Month Day Year <u>JULY - 22 1967</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB-11-1967</u>
9. AGE (In years last birthday) yrs. <u>5 11</u>		10. IF UNDER 1 YEAR Months Days Hours Min. <u>5 11</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>HAGERSTOWN WASH. Co. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDWARD STEVENS</u>		14. MOTHER'S MAIDEN NAME <u>BONNIE KERSHNER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EDWARD STEVENS</u>		Address <u>FAIRPLAY MD. R. 1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>491X ASPIRATION PNEUMONIA</u> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. _____			INTERVAL BETWEEN ONSET AND DEATH <u>SUDDEN</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>MULTIPLE CONGENITAL ANOMALY</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5/17</u> , 19 <u>67</u> to <u>7/22</u> , 1967, that (I) (we) last saw the deceased alive on <u>7/22</u> , 1967, and that death occurred at <u>11:30</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>7/24/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RIZALITO AMARILLO</u>		22d. ADDRESS <u>SHARPSBURG, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>7-25-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GREEN LAWN CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>WILLIAMSPORT WASH. Co. MD</u>
24. FUNERAL DIRECTOR <u>[Signature]</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
ADDRESS <u>200 S. BOONSBORO MD.</u>		DATE <u>JUL 26 1967</u>	

1962

CERTIFICATE OF DEATH

DECEASED

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

SIGNATURE OF PHYSICIAN

DATE OF SIGNATURE

PLACE OF SIGNATURE

REMARKS

DATE OF ENTRY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10221

CERTIFICATE OF DEATH

10219

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK		c. LENGTH OF STAY IN 1b 25 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HANCOCK 21-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #1, HANCOCK, MARYLAND				d. STREET ADDRESS RFD #1		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RUTH Middle BROOK Last TANEYHILL				4. DATE OF DEATH Month JULY Day 12 Year 1967			
5. SEX F	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/22/1887		9. AGE (In years last birthday) 80 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) WASHIN GTON CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE H. BROOK				14. MOTHER'S MAIDEN NAME ADA TAYLOR			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 217-36-0568		17. INFORMANT JAMES R. BROOK RD. #1 HANCOCK, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO (b) Atherosclerotic Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure						INTERVAL BETWEEN ONSET AND DEATH 9 hrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 10 , 1967, to July 12 , 1967, that (I) (we) last saw the deceased alive on July 10 , 1967, and that death occurred at 9:30 AM , from causes and on the date stated above.							
22a. SIGNATURE Charles R. Wierer				22b. DATE SIGNED 7-12-67		22c. PHYSICIAN'S NAME (Type) CHARLES R. WIERER	
22d. ADDRESS HANCOCK, MARYLAND				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/15/67		23c. NAME OF CEMETERY OR CREMATORY CATALPA METHODIST		23d. LOCATION (City or Town) (County) (State) RURAL HANCOCK MD.	
24. FUNERAL DIRECTOR Richard L. Lione				25. REC'D BY REGISTRAR JUL 17 1967			

10017

WASHINGTON

MARYLAND

WASHINGTON

RURAL HANCOCK

25 YEARS

RURAL HANCOCK

RTD 1, HANCOCK, MARYLAND

RTD 1

X

RUTH

BROOK

TAKENHILL

JULY 12

87

WHITE

X

2/22/1907

80

HOUSEHOLD

WASHINGTON CO. MD. U.S.A.

GEORGE H. BROOK

ADA TAYLOR

212-30-0500 JAMES B. BROOK RD. 1 HANCOCK, MD.

HANCOCK, MARYLAND

CHARLES A. BIERER

BURIAL

DATA AREA METHODIST

RURAL HANCOCK, MD.

JULY 12 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

10222

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10220

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1d 2 days	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS RFD #1 Williamsport	
3. NAME OF DECEASED (Type or print) First GEORGE Middle ELAIR Last TRUITT Sr.		4. DATE OF DEATH Month July Day 16 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 25 1908
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR Months 0 Days 20 IF UNDER 24 HRS. Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Lumber & Supplies	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Samuel Truitt		14. MOTHER'S MAIDEN NAME Ida Mae Bixler	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-03 8202	
17. INFORMANT Mrs. Lillian D. Truitt		Address Williamsport Md. RFD #1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) massive post. lateral infarction 4201 DUE TO (b) Rt. coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none		INTERVAL BETWEEN ONSET AND DEATH 10m.4 ?	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July , 19 63 , to July 16 , 19 67 , that (II) (we) last saw the deceased alive on July 16 1967 and that death occurred at 4:20 PM , from the causes and on the date stated above.			
22a. SIGNATURE Max E. Byrkit		22b. DATE SIGNED 7-17-67	
22c. PHYSICIAN'S NAME (Type) Max E. Byrkit M.D.		22d. ADDRESS Williamsport, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 19-67	
23c. NAME OF CEMETERY OR CREMATORY Lorrain Cemetery		23d. LOCATION (City, town or county) (State) Baltimore Maryland	
24. FUNERAL DIRECTOR Albert L. Leaf		25a. REC'D BY REGISTRAR 19 1967	
ADDRESS Williamsport, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

100-100000

TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Penna</u> b. COUNTY <u>Schuylkill</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>RD #1, Ashland</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Avalon Manor Home</u>					d. STREET ADDRESS <u>RD #1</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>William Joseph Wagner</u>					4. DATE OF DEATH Month Day Year <u>July 13, 1967</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 2, 1885		9. AGE (In years last birthday) <u>82</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Road work</u>				
11. BIRTHPLACE (County & State, or foreign country) <u>Schuylkill Co Penna</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>John Z Wagner</u>					14. MOTHER'S MAIDEN NAME <u>Sarah Bixler</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>185-09-6428</u>				
17. INFORMANT <u>John L. Howe, Hagerstown, Pa</u>					Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Generalized</u> DUE TO (c) <u>Diabetes Mellitus</u>									INTERVAL BETWEEN ONSET AND DEATH <u>1 WK.</u> <u>2 yrs +</u> <u>2 yrs +</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Feb 17</u> , 19 <u>66</u> to <u>July 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>JULY 13</u> , 19 <u>67</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Carl A. Hoffman</u> M.D.					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>					22d. ADDRESS <u>Hagerstown, Md</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
<u>Burial</u>			<u>7/16/1967</u>		<u>St Johns Cemetery</u>		<u>Ashland, Schuylkill Co Pa</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>Harold H. Zimmerman</u>					25. REC'D BY REGISTRAR <u>Charles Judge</u>				
25b. REGISTRAR'S SIGNATURE					DATE <u>JUL 17 1967</u>				

8833

DATE OF DEATH

1

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY WASHINGTON COUNTY MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE PENNSYLVANIA b. COUNTY Fulton	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HANCOCK		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Warfordsburg	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Warfordsburg Road near Hancock		d. STREET ADDRESS Rural Warfordsburg	
3. NAME OF DECEASED (Type or print) First HAYES Middle EMANUEL Last WARD		4. DATE OF DEATH Month JULY Day 9 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/26/1915
9. AGE (In years lost birthday) yrs. 52		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY N.A.	
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME AMOS WARD		14. MOTHER'S MAIDEN NAME ORA SCRIEVER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES W.W. 2		16. SOCIAL SECURITY NO. 054-14-4643	
17. INFORMANT ALFRETTA L. WARD WARFORDSBURG, PA.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Alcoholism With Exposure DUE TO (a) Acute alcoholism (Blood 0.21 per cent ethyl alcohol) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Aspiration of Vomitus DUE TO (c) Chronic alcoholism with exposure		INTERVAL BETWEEN ONSET AND DEATH Several hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Patient has been a very user of alcohol.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>			
ACTUAL SIGNATURE A. E. W. Ditto, Jr.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county) Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 7/13/67	
23c. NAME OF CEMETERY OR CREMATORY BUCK VALLEY METHODIST		23d. LOCATION (City or Town) (County) (State) WARFORDSBURG FULTON, PA.	
24. FUNERAL DIRECTOR Richard J. Inoue Hancock, Md.		25a. REC'D BY REGISTRAR JUL 17 1967	
		25b. DECEASED'S SIGNATURE Richard J. Inoue	

PENNSYLVANIA

WASHINGTON COUNTY

HANCOCK

107

JULY

HARD

CHAMBER

LAYER

ASSOCIATED

WHITE

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U.S.A.

PENNSYLVANIA

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LABORER

ORA SOBIEV

AND WARD

WASHINGTON COUNTY, PENNSYLVANIA

W.M. 2

BUCK VALLEY METHODIST HOSPITAL, FULTON, PA.

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JUL 11 1935

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10225

CERTIFICATE OF DEATH

10223

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md. c. LENGTH OF STAY IN 1b 40yrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland d. STREET ADDRESS 341 Suter Alley. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Martha Elizabeth Washington		4. DATE OF DEATH Month July Day 12 Year 1967	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 29 1905
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11	11. IF UNDER 24 HRS. Hours 11 Min. 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Private family	11. BIRTHPLACE (County & State, or foreign country) Markham, Va.
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Dan Washington	
14. MOTHER'S MAIDEN NAME UNknow		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no	
16. SOCIAL SECURITY NO. 216-303543		17. INFORMANT Mrs. Mary Johnson	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 1533 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ca of Sigmoid Colon DUE TO (c) 4 mos		INTERVAL BETWEEN ONSET AND DEATH 16 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Right hemiplegia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 6/26/67 , 19__ to 7/12/67 , 19__, that (I) (we) last saw the deceased alive on 7/12/67 , 19__, and that death occurred at 5:10 P.M. from causes and on the date stated above.			
22a. SIGNATURE John A. Moran		22b. DATE SIGNED 7/17/67	
22c. PHYSICIAN'S NAME (Type) John A. Moran, M.D.		22d. ADDRESS 215 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 7-20-1967	23c. NAME OF CEMETERY OR CREMATORY Mt Morris	23d. LOCATION (City or Town) (County) (State) Hume, Va.
24. FUNERAL DIRECTOR John R Watson Jr. Hagerstown Md.		25. REGISTRAR'S SIGNATURE Charles Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10226

CERTIFICATE OF DEATH

10224

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY in 1b <u>49 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> <u>211</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>203 West Side Ave.</u>				d. STREET ADDRESS <u>203 West Side Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Doc</u> Middle <u>Joseph</u> Last <u>Weaver</u>		4. DATE OF DEATH Month <u>July</u> Day <u>27</u> Year <u>19 67</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 5, 1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Flour Mill</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bentonville, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ernest Powell Weaver</u>				14. MOTHER'S MAIDEN NAME <u>Alice Clarinda Matthews</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-3068</u>		17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Mary C. Weaver 203 West Side Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cachexia</u> <u>177X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>adenocarcinoma of prostate with metastasis</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>None</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u>none</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>none</u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>62</u> , to <u>July</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>July 14</u> , 19 <u>67</u> , and that death occurred at <u>P.</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>Harold R. Tritch, Jr.</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>7-28-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Harold R. Tritch, Jr M.D.</u>		22d. ADDRESS <u>302 N. Potomac St Hagerstown, Md</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>7/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington, Md.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>		ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>JUL 31 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10227

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10225

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>57 YEARS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> <u>211</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>91 WESTERN MARYLAND STATE HOSPITAL</u>				d. STREET ADDRESS <u>35 EAST AVENUE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MAE</u> Middle <u>HAINES</u> Last <u>WEMPE</u>				4. DATE OF DEATH Month <u>JULY</u> Day <u>15</u> Year <u>19 67</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 16, 1885</u>		9. AGE (In years last birthday) <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>LURAY, VIRGINIA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>HAINES</u>				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u> <u>****</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>911 FREDERICK STREET,</u> <u>MR. MARTIN E. WEMPE, HAGERSTOWN, MARYLAND.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho Pneumonia</u> <u>4221</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular Disease</u> DUE TO (c) <u>Fracture Hip</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>Several years</u> <u>63 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in her home.</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>5-12</u> <u>19 67</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Hagerstown, Washington, Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>E. W. DITTO, JR.</u>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <u>215 W. WASH. JULY 17,</u> <u>HAGERSTOWN, MARYLAND. 1967</u>	
EXAMINER'S NAME (Type)		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>7/18/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ROSE HILL CEMETERY</u>	
24. FUNERAL DIRECTOR <u>CHARLES M. ROUZER, HAGERSTOWN, MARYLAND.</u>		23d. LOCATION (City or town) (County) (State) <u>HAGERSTOWN, WASH. CO. MD.</u>		23e. REC'D BY REGISTRAR'S SIGNATURE <u>JUL 19 1967</u>		23f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form FM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10228

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10228

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville		c. LENGTH OF STAY IN 1b 5 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Maugansville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 412 N. Main St.				d. STREET ADDRESS 412 N. Main St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Maud Middle Alice Last Willey				4. DATE OF DEATH Month July Day 10 Year 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-11-1886	9. AGE (In years last birthday) yrs. 80	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher		10b. KIND OF BUSINESS OR INDUSTRY college		11. BIRTHPLACE (State or foreign country) Mead, Nebr.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Jay Willey				14. MOTHER'S MAIDEN NAME Elizabeth Gilchrist			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Address Mrs. Cliff Zicafoose, Mead, Nebr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 2nd. & 3rd. degree burns of chest, shoulders DUE TO (c) & face. Several years Several hours						INTERVAL BETWEEN ONSET AND DEATH Several years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Patient fell from commode on to small electric heater.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 7-10- p.m. 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Maugansville, Washington, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>							
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 7-14-67	
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 7-17-67		23c. NAME OF CEMETERY OR CREMATORY Sunrise Cemetery		23d. LOCATION (City or Town) (County) (State) Wahoo, Nebr.	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUL 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

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UNITED STATES DEPARTMENT OF THE INTERIOR

LAND OFFICE

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Section 10, T. 1 N., R. 1 E., S. 10 E.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10229

CERTIFICATE OF DEATH

10227

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A. time		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg rural 10.2			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Foxville		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sadie Marie Wolfe				4. DATE OF DEATH Month Day Year July 4 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 2-4-1900		9. AGE (In years last birthday) 67 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lewis Smith				14. MOTHER'S MAIDEN NAME Emaline Comfort			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-20-1757		17. INFORMANT Address Elaine Baker Smithsburg, Md. RD 1			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO arteriosclerosis Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO Myocardial infarction (c) Myocardial infarction						INTERVAL BETWEEN ONSET AND DEATH 1 hr UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5-14 , 19 67 , to 6-12 , 19 67 , that (I) (we) last saw the deceased alive on 6-12 , 19 67 , and that death occurred at 7:45 P.M. from causes and on the date stated above.							
22a. SIGNATURE E. R. Lardizabal				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 7-5-1967	
22c. PHYSICIAN'S NAME (Type) E. R. Lardizabal, M. D.				22d. ADDRESS 300 North Potomac St. Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 7-7-67		23c. NAME OF CEMETERY OR CREMATORY Mt. Moriah Cemetery		23d. LOCATION (City or Town) (County) (State) Foxville Fred. Co. Md.	
24. FUNERAL DIRECTOR Raymond E. Creager Thurmont, Md.				25a. REC'D BY REGISTRAR DATE JUL 10 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

10230

CERTIFICATE OF DEATH

10228

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b --			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				e. STREET ADDRESS 837 Virginia Ave			
3. NAME OF DECEASED (Type or print) Premature Baby Boy of Joseph J. Young				4. DATE OF DEATH July 28 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 28.1967	
9. AGE (In years last birthday) 2		10. IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph J. Young				14. MOTHER'S MAIDEN NAME Linda Sipes			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph J. Young		18. ADDRESS 137 Va. Ave Hagerstown, Md.	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity (1 lb-4 oz) 7625 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Unexplained DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 2 hr 15 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/28/67 , 19 67 , to 7/28/67 , 19 67 , that (I) (we) last saw the deceased alive on 7/28/67 , 19 67 , and that death occurred at 9:20 AM , from causes and on the date stated above.							
22a. SIGNATURE A.M. Bacon				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) A.M. Bacon R M.D.	
22d. ADDRESS 101 King St Hagerstown Md.				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ATTENDING PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF July 29/67		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery near Tilghmanton Wash Co		23d. LOCATION (City or Town) (County) (State) Md	
24. FUNERAL DIRECTOR Hagerstown Md. Andrew K. Coffman Funeral Home Inc				25a. REC'D BY REGISTRAR JUL 31 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

1004

STATEMENT OF DEATH

Washington

Washington

Hagerstown

Hagerstown

Hagerstown County Hospital

307 Virginia Ave

Progressive Baby Boy & Jeanne J. Young

July 28, 1957

July 28, 1957

Hagerstown, Md.

Hagerstown, Md.

Joseph J. Young

Linna Roper

Joseph J. Young, Hagerstown, Md.

Hagerstown, Md.

Hagerstown, Md.

Hagerstown, Md.

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